Supreme Court, U. S.
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Nos. 79-1404, 79-1408,
79-1414, 79-1415, 79-1489

IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1980

Pennhurst State School and
Hospital, et al.,

Petitioners

v.

Terri Lee Halderman, et al.

Pennsylvania Association for
Retarded Citizens, et al.

and

United States of America,

Respondents

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

JOINT APPENDIX
VOLUME I, A241-A385

Petitions for Certiorari Filed March 12 and 20, 1980.
Certiorari Granted June 9, 1980.

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CHRONOLOGICAL LIST OF RELEVANT DOCKET ENTRIES

May 30, 1974	Complaint of plaintiffs Halderman et al. filed
November 25, 1974	Motion of United States to intervene as party plaintiff
January 17, 1975	Order granting motion of United States to intervene as party plaintiff
June 3, 1975	Motion of Pennsylvania Association for Retarded Children to intervene as party plaintiffs
October 6, 1975	Order enjoining defendants from admitting into Pennhurst any person adjudicated as delinquent
November 13, 1975	Order granting motion of Pennsylvania Association for Retarded Citizens et al., to intervene as party plaintiffs
January 8, 1976	Amended Complaint of Pennsylvania Association for Retarded Citizens filed
March 3, 1976	Plaintiff Halderman's motion for leave to file second amended complaint filed
April 5, 1976	Defendants' motion to dismiss plaintiff intervenor P.A.R.C.
November 30, 1976	Order granting leave to plaintiffs to file second amended complaint; ruling upon various motions to dismiss and ruling that litigation be maintained as a class action

CHRONOLOGICAL LIST OF RELEVANT DOCKET ENTRIES — *(Continued)*

January 4, 1977	Order that defendants are enjoined from altering or removing anything from any records at Pennhurst subject to discovery
February 4, 1977	Order denying Commonwealth's motion to stay participation of United States
April 18, 1977	Order of Court of Appeals denying Commonwealth application for stay of further participation by United States
April 18, 1977	Trial commences
December 23, 1977	Opinion and Order of Broderick, J. finding constitutional and statutory rights of retarded residents of Pennhurst violated, and setting hearing to determine appropriate relief to be granted
March 17, 1978	Order entering judgment for plaintiffs and granting injunctive relief
May 9, 1978	Order of district court denying defendants' motion for a stay of the Order of 3/17/78
May 10, 1978	Notice of Appeal filed in U.S. Court of Appeals for the Third Circuit
June 21, 1978	Order of district court dismissing petition of Pennhurst Parents-Staff Association to intervene
June 30, 1978	Order appointing Special Master

CHRONOLOGICAL LIST
OF RELEVANT DOCKET ENTRIES — *(Continued)*

September 6, 1978	Order of Court of Appeals denying motion of Pennhurst Parent-Staff Association for leave to intervene without prejudice to pending appeal raising such issue
January 9, 1979	Appeal Argued. Coram: Seitz, Ch. J., Gibbons and Higginbotham, C.J.
July 6, 1979	Order listing cases for rehearing before the Court of Appeals *en banc*
August 6, 1979	Order of Court of Appeals granting partial stay of district court order of June 8, 1979
August 24, 1979	Order of Court of Appeals denying motion of AFSCME (Council 13) and its District Council 88, Amicus Curiae for leave to participate in oral argument
December 13, 1979	Judgment on Rehearing affirming the judgment of the district court except in three respects, Opinion of the Court of Appeals filed together with separate dissenting opinion
March 5, 1980	Order directing mandate reissue upon entry of order, granting motion of Pennhurst-Parent-Staff Association to intervene
March 12, 1980	Petitions for Certiorari filed by Commonwealth of Pennsylva-

	nia, Suburban Counties, Philadelphia; Conditional Cross Petition filed by P.A.R.C. et al.
March 20, 1980	Petition for Certiorari filed by Pennhurst Parent-Staff Association
May 12, 1980	Order of Court of Appeals denying motion of Pennhurst Parent-Staff Association for stay of district court orders pending certiorari
June 9, 1980	Petition for writ of certiorari granted
June 30, 1980	Order granting petitioners' motion for a stay of the judgment of the Court of Appeals, pending final disposition of the cases in the Supreme Court to the extent that the judgment mandates the movement of residents of the Pennhurst facility to "appropriate community living arrangements" and denying the motion in all other respects. Mr. Justice Brennan, Mr. Justice Marshall, Mr. Justice Blackmun and Mr. Justice Powell would have denied the motion.

District Court Opinion, May 9, 1978

Terri Lee HALDERMAN et al., Plaintiffs,

Pennsylvania Association for Retarded Citizens et al., Plaintiffs-Intervenors,

United States of America, Plaintiff-Intervenor,

v.

PENNHURST STATE SCHOOL AND HOSPITAL et al., Defendants.

Civ. A. No. 74-1345.

United States District Court, E. D. Pennsylvania.

May 9, 1978.

MEMORANDUM

RAYMOND J. BRODERICK, District Judge.

In an opinion filed on December 23, 1977, 446 F.Supp. 1295, this Court held that the constitutional and statutory rights of the retarded at Pennhurst State School and Hospital ("Pennhurst") had been and are being violated. As set forth in our memorandum of March 17, 1978, which accompanied the Court's Order in this case,

some of the determinations made by the Court in its opinion were:

> 1. That when a state institutionalizes individuals because they are retarded, the United States Constitution (Eighth and Fourteenth Amendments) and the laws of Pennsylvania (50 P.S. §§4101 et seq.) require the state to provide such minimally adequate habilitation as will afford a reasonable opportunity for them to acquire and maintain such life skills as are necessary to enable them to cope as effectively as their capacities permit.
>
> 2. That the Rehabilitation Act of 1973, 29 U.S.C. §794, grants rights to the retarded residents of Pennhurst, which rights have been and are being violated.
>
> 3. That the retarded at Pennhurst are not receiving minimally adequate habilitation and that such minimally adequate habilitation cannot be provided at Pennhurst because it does not provide an atmosphere conducive to normalization, which all the experts agree is vital to the minimally adequate habilitation of the retarded.

Based upon these and other determinations, this Court ordered appropriate injunctive relief. Commonwealth defendants and Bucks, Chester, Delaware, Montgomery and Philadelphia Counties have filed notices of appeal from the Court's judgment. The Commonwealth now seeks a stay of the judgment order pending a determination of its appeal by the Third Circuit.

[1,2] On April 13, 1978, a hearing was held in connection with the Commonwealth's motion to stay the judgment and, for the reasons hereinafter set forth, the motion will be denied.

Fed.R.Civ.P. 62(c) provides in pertinent part that:

> When an appeal is taken from an interlocutory or final judgment granting, dissolving, or denying an in-

> junction, the court in its discretion may suspend, modify, restore, or grant an injunction during the pendency of the appeal upon such terms as to bond or otherwise as it considers proper for the security of the rights of the adverse party.

It is well settled by the case law that a party seeking the stay of a judgment order must show (1) that it will likely prevail on the merits of the appeal, (2) that it will suffer irreparable injury if the stay is denied, (3) that other parties will not be substantially harmed by the stay, and (4) that the public interest will be served by granting the stay. *Philadelphia Counsel of Neighborhood Organizations v. Adams*, 451 F.Supp. 114 (E.D.Pa.1978); *Long v. Robinson*, 432 F.2d 977, 979 (4th Cir. 1970); *Resident Advisory Board v. Rizzo*, 429 F.Supp. 222, 224 (E.D.Pa.1977). A motion requesting a stay of a judgment order is addressed to the discretion of the court. The Third Circuit has recently stated that in considering the four-prong test enumerated above, the district court should realize that

> these [four] factors structure the inquiry, however, no one aspect will necessarily determine its outcome. Rather, proper judgment entails a "delicate balancing" of all elements.

Constructors Association of Western Pennsylvania v. Kreps, 573 F.2d 811, 815, (3d Cir. 1978). *See, Evans v. Buchanan*, 424 F.Supp. 875, 879 (D.Del.1976).

1. *Likelihood of Success on Appeal*[1]

Commonwealth defendants contend that "[t]his Court's decision and order are novel and precedent set-

---

1. There is disagreement among the circuits as to the degree of likelihood of success which must be shown. *See Resident Advisory Board v. Rizzo*, 429 F.Supp. 222, 224 n.1 (E.D.Pa. 1977). We do not herein make any determination as to the degree of certainty which must be shown, since we find that the Commonwealth has not satisfied even the least rigorous of the standards, *i.e.*, mere likelihood of success on appeal.

ting, both in the rights enunciated and the scope of relief granted. . . . The novelty of the decision and order above is itself more than sufficient reason to grant a stay." However, as we have heretofore pointed out, the Court's judgment was based on several alternate legal theories, any one of which is sufficient to sustain the judgment. Several of these theories have been accepted by the courts which have considered them. See discussion of these cases in *Halderman v. Pennhurst*, 446 F.Supp. 1295, 1316-17, 1319 (ED.Pa.1977).

2. *Irreparable Injury to Commonwealth Defendants*

The Commonwealth contends that failure to stay the Court's Order of March 17, 1978 will cause irreparable injury in that compliance will require the expenditure of vast sums of money. In view of the testimony given by Commonwealth witnesses at trial that the Commonwealth intended to move all the retarded residents from Pennhurst into community facilities, the Commonwealth's contention that the Court's Order requiring this to be done will cause irreparable injury is unpersuasive. As the Court found in its opinion of December 23, 1977:

> Having concluded the trial phase of the liability portion of this litigation, it has become apparent that by and large the parties share the same goals: all desire to improve the education, training and care provided the retarded in Pennsylvania and believe that Pennhurst should be closed and that all residents should be educated, trained and cared for in the community. All agree that institutions such as Pennhurst are inappropriate and inadequate for the habilitation of the retarded. Defendants agree with plaintiffs' contention that the habilitation provided Pennhurst residents does not meet minimally acceptable professional standards. The Commonwealth in recent years has been attempting to up-

> grade Pennhurst and the education, training and care provided therein to its retarded residents. Moreover, the Pennsylvania Department of Public Welfare's current plans call for the transfer of all Pennhurst residents from the institution into the community (though perhaps temporarily into other institutions) by the early 1980's.
>
> *Halderman v. Pennhurst*, 446 F.Supp. at 1313.

The Commonwealth's irreparable injury argument becomes even less persuasive when one considers that in 1970, Act 256 was signed by the Governor of Pennsylvania. This Act appropriated $21,000,000 for the purpose of planning, designing and constructing community facilities which would enable 900 Pennhurst residents to be transferred to the community. As the record in this case shows, although seven and one-half years have gone by, few Pennhurst residents have been moved into community facilities pursuant to the legislation. Over $18,000,000 remains unspent. *Halderman v. Pennhurst*, 446 F.Supp. at 1311-1312.

The argument that the cost of compliance with the Court's Order will bring irreparable injury to the Commonwealth loses all credibility in light of the Court's finding that providing habilitative services for the retarded in the community is less expensive than operating a large isolated institution such as Pennhurst. As the Court found in its opinion of December 23, 1977:

> Comparable facilities in the community are generally less expensive than large isolated state institutions. Services can be purchased at regular rates, rather than at rates which must be paid to attract individuals to work in a setting like Pennhurst. The cost of running Pennhurst in 1976 was $27.8 million dollars, or $60 per resident per day. This does not include the fair rental value of the build-

> ings at Pennhurst (estimated at $3-$4 per resident per day). The statewide cost of community living arrangements in Pennsylvania for 1976 was $17.64 per individual per day. Program services, which one-third of mentally retarded individuals would need, average approximately $10 per individual per day. Moreover, keeping the retarded individual in the community makes it possible for him or her to get employment. Eighty-five percent of the mentally retarded can be employed, though not all are capable of competitive employment. The lifetime earnings of a mildly retarded individual often exceeds $500,000. For those with an I.Q. between 25 and 50, 45% of men and 12% of women earn about 20% of the average wage. When the retarded can work, the amount of financial support which society must provide decreases and the individuals may benefit society with the taxes they pay. Furthermore, the investment per individual at Pennhurst is primarily for warehousing and not for the individual's well-being or future planning, as is the case with community facilities.
>
> *Halderman v. Pennhurst*, 446 F.Supp. at 1312 (citations omitted).

The Commonwealth also contends that it will lose federal financial assistance if the Court's Order is not stayed. Throughout the trial, the Commonwealth stressed the fact that retarded individuals residing in community living arrangements were not eligible for federal medical assistance funds (Title XIX) while those residing in Pennhurst were. However, in regulations published March 10, 1978, effective *October 1, 1976*, Title XIX funds became available to the eligible retarded living in public community residences housing no more than 16 persons. 42 C.F.R. §448.60, 43 Fed.Reg. 9810, 9816 (March 10, 1978). Moreover, the eligible retarded can now receive supplemental security income (SSI)

benefits. 20 C.F.R. §416.231(a)(4), 43 Fed.Reg. 4004, 4006 (January 31, 1978). Additionally, it appears that federal loans are now available for the construction of community facilities for the retarded pursuant to section 202 of the Housing Act of 1959, as amended, 12 U.S.C. §1701q. 24 C.F.R. §885, 43 Fed.Reg. 8492 (March 1, 1978).

The Court's judgment and order assures that the Commonwealth's own goals for the retarded are implemented and its contention that a failure to stay the judgment will bring irreparable injury is without merit.

3. *Injury to Plaintiffs from a Stay*

As the Court's opinion of December 23, 1977 demonstrates, the retarded residents of Pennhurst have endured severe and widespread deprivations of their constitutional and statutory rights — deprivations which continue to this day. The Court's Order of March 17, 1978 was designed to alleviate these deprivations. Delay in implementing that Order would result in further irreparable injury to the plaintiffs.

4. *Public Interest*

[3] Commonwealth defendants contend that the public interest would benefit from a stay. We do not agree. The public interest will never benefit from a failure to provide minimally adequate habilitation to its retarded citizens. This Court's Order represents nothing more than a judicial recognition that the retarded have constitutional and statutory rights which must not be denied.

[4] Having carefully considered all the contentions of the Commonwealth and having balanced the equities, we shall enter an Order denying the Commonwealth's motion requesting a stay of this Court's Order of March 17, 1978.

[Testimony of Philip Roos]

* * *

P. ROOS — direct

[1-85] BY MR. THRASHER:

Q. Dr. Roos, what is mental retardation, sir?

A. Mental retardation is essentially a problem of learning, a defect particularly of the individual's ability to think abstractly, to exercise judgments, to solve problems, and to retain information.

The definition of the American Association of Mental Deficiency is a generally-accepted one today
[1-86] and that defines mental retardation as significantly subaverage general intellectual functioning, existing concurrently with deficits in adaptive behavior and manifestations during the developmental period, which refers to eighteen years of age or younger.

Usually we look at measured intelligence. A retarded individual scores on the test of general intelligence at least two standard deviations below the mean.

We also look at the child's adaptive behavior, and this refers to such things as sensory-motor development, self-help skills, language, vocalization; and in later life academic and social skills, the ability of the individual to cope with the environment and his vocational and social accomplishments.

Q. And how are these indicia measured, Dr. Roos?

A. Mental intelligence is usually measured in terms of so-called intelligence quotient or IQ. The average population score is 100. The retarded individuals usually score seventy or below.

Adaptive behavior is measured in terms of a social quotient, which is expressed in terms of essen-

tially a similar type of numerical score and which refers to the individual's ability to deal with the social environment.

Q. Are there any problems with these types of measurement of mental retardation?

[1-87] A. In recent years, particularly problems have become apparent in that the tests in common use a strong self-help bias and, in addition, performance is influenced by the individual's motivation, physically, anxiety, experiences, and whether or not he has learned to anticipate failure. Individuals who anticipate failure because of the fact of failure tend to do more poorly.

Q. Also, mental disease, mental illness, and mental retardation are confused.

Does mental retardation differ from mental illness?

A. Yes. They are two entirely different conditions.

Mental retardation refers primarily to a deficit in intellectual development and social adaptation, whereas mental illness refers to disorder of thinking, emotions, and behavior.

Mental retardation occurs usually either prior to, at, or shortly following birth; whereas mental illness can occur at any time in life and often the onset is during adulthood.

Mental retardation is primarily an educational problem; mental illness is primarily a psychiatric problem.

Whereas mental retardation is essentially irreversible, that is, although it can be improved, there is at this stage of our knowledge no cure; mental ill-

[1-88] ness is often reversible and curable.

* * *

BY MR. THRASHER

Q. Dr. Roos, can mentally-retarded persons, in addition to being mentally retarded, also be mentally ill?

A. Yes, they can, although most mentally-retarded persons are not mentally ill. There are some who in addition to mental retardation also suffer from a mental illness.

Q. Are the causes of mental retardation known today?

A. At least 250 separate causes have been recognized to today. However, in approximately seventy-five percent of the cases of mental retardation the cause is not known.

We do know that anyone who is responsible, that there are many potential conditions that will lead to mental retardation, including such diverse situations as infections in the mother during pregnancy, high fever in a young child, certain specific infections in the child, problems in nutrition, both in the pregnant mother and in the young child, inborn errors of metabolism, toxins in the entire system, such as lead, mercury, various types of unknown genetic conditions, certain hereditary situations, early environmental deprivations, and various kinds of trauma in nature; and these are just representative of some of the different types of conditions that may lead to retardation.

Q. Is mental retardation undifferentiated or are there different degrees of mental retardation?

A. There are different degrees of mental retardation. Essentially four basic levels are recognized today.

The mild level of mental retardation includes
[1-90] roughly eighty-nine percent of the mentally-retarded population, individuals whose IQs range between roughly fifty-two and sixty-seven.

The moderate degree of mental retardation includes six percent of the retarded population. These are individuals with IQs between thirty-six and fifty-two.

The severely mentally-retarded have IQs between twenty and thirty-five, and the most seriously incapacitated we refer to as those with profound mental retardation and they have IQs below twenty. Approximately twenty percent of the population fall in the severe and profound range.

BY THE COURT:

Q. You have combined those percentagewise?

A. I have combined those percentagewise. There are more severe than profound. Probably three to three and a half percent are the severe; the remainder are profound.

Q. Doctor, I may have put down the wrong numbers. Maybe it is not significant at all, but when you say eighty-nine percent generally fall within the mild category —

A. Right.

Q. — and six percent in the moderate?

A. In the moderate, —

Q. And then the remaining five?

A. The remaining five in the severe and profound.

THE COURT: I understand.

Let's proceed.

[1-91] BY MR. THRASHER:

Q. Dr. Roos, do you have any knowledge as to the prevalence or incidence rates of mental retardation in our society?

A. The general opinion today is that the incidence of mental retardation is less than three percent, suggesting then that some six and a half million United States citizens will at some time in their lives be labeled as mentally retarded.

The prevalence rate is probably close to two million at any one time.

Q. Have you made any determination as to the understanding of the public at large as to the condition of mentai retardation?

A. One of the big problems for the mentally-retarded person has been lack of general understanding. Indeed, there is a long history of myths, of distorted views on mental retardation which are still lingering today.

For instance, retarded individuals are often perceived as being subhuman, as not possessing the same needs, the same rights as individuals of normal intelligence.

In the past sometimes they have been managed much as animals because of the assumption that
[1-92] they did not require these human needs.

Others perceive them as a menace or potential threat to Society and hence, in the past, institutions have tended to develop as prisons with guard rails, bars, locked doors, and such as that.

Others regard retarded persons as an object of pity, to be nurtured and sheltered and consequently deprived of dignity.

Another myth is that retarded people are eternal children and hence they can be happy kept and over-protected.

Finally there is a myth that retarded persons are diseased or ill in some fashion and hence they should be hospitalized and given medical treatment.

Unfortunately, these myths, which are prevalent among the lay public, are still held by some professionals as well.

Q. Dr. Roos, we know, of course, that mentally-retarded persons reside at Pennhurst.

Do you have any knowledge as to how many retarded persons reside at institutions throughout the United States?

A. The latest data in 1976 suggest some 154,000 are residing in state-operated public facilities. There is an estimate that probably another 32,000 live in
[1-93] mental hospitals, that is hospitals for mentally-ill, and probably an equivalent number live in private institutions of various kinds.

BY THE COURT:

Q. Equivalent number to what?

A. To those in the mental hospitals — thirty-two to thirty-three thousand.

THE COURT: All right.

BY MR. THRASHER:

Q. Doctor, do you have any knowledge as to whether or not the number so residing in institutions is changing, growing, getting smaller?

A. Between 1860 and 1960 there was a marked increase. Since 1966 the rate of institutionalization has been declining according to the data compiled by the Department of Health, Education, and Welfare.

In 1966 the rate of people residing in institutions was almost 99 per 100,000. By 1970 this had decreased to 94 per 100,000; and by 1976 to 71 per 100,000.

A survey conducted in 1972 of the state institutions indicated that 72 percent of the responding institutions showed a decline in the past five years.

Q. Are you aware of the reasons for this trend.?

A. There are probably a number of reasons operating. Certainly, one is the increasing philosophy of deinstitutionalization.

[1-94] There has also been a gradual growth of alternative community resources.

Disappointment in institutions has had an impact, and finally I should mention the new technologies which have become available and which have

made it possible to habilitate and socialize, as far as individuals who, prior to the advent of the technology, were considered to be essentially hopeless.

Q. Have you made any review of the literature of mental retardation to determine how it is that such institutions have developed in this country?

A. The onset of these institutions is some time in the mid-1800s —

THE COURT: Let me just make sure I understand the question; he apparently does.

BY THE COURT:

Q. When you say the onset of these institutions, which ones?

A. The large state mental-retardation institutions, such as Pennhurst.

Q. All right. Yes.

A. The first institutions were developed in the mid-1800s essentially as habilitation facilities for the design of educating the residents and returning them to a productive life in the community. The philos-
[1-95] ophy was to make deviant people non-deviant.

Gradually, however, the philosophy changed and the institutions became sanctuaries to protect the retarded persons from Society. During this stage of their development they changed gradually into warehouses.

Sometime later the facilities became prison-like in that the main purpose was to protect Society from the retarded individuals who were perceived as potentially dangerous.

Relatively recently, well into the Twentieth Century, institutions became again habilitation facilities.

Still more recently questions were raised about the viability of institutions as effective habilitation centers. In recent years the thrust has been toward

community placement, not with regard to mental retardation but as a general social phenomenon.

BY MR. THRASHER:

Q. Doctor, you mentioned the word "habilitation" several times in your testimony.

Would you define that for the Court, please?

A. That's a generic term we use to refer to the many specific activities designed to foster maximum development of the individual. Included in the term are various approaches to education, the development of social and intellectual skills, the development of pre-vocational and vocational skills, and related types of activities.

[1-96]

Q. Are you aware in your profession, Doctor, of the results of evaluations of institutionalization of mentally-retarded persons?

A. Yes, sir.

Q. And what are they?

A. The major findings can be summarized as follows:

Generally institutions are less conducive to child-rearing than are home settings. In general, the younger the child is placed in an institution the more destructive the placement is likely to be. Likewise, the longer the placement, the more destructive it is likely to be.

The research literature has reported a number of detrimental effects of institutionalization. They include detrimental effects on cognitives, that is, intellectual development; on social and personality development, including the development of stereotyped and self-stimulating behavior on the part of the individual; in case dependency, negative attitudes toward the self, decreases in social quotient, retarded motor development, losses in IQ points, appetite reduction in language development and stunted physical growth.

Q. Doctor, you mentioned stereotypic and self-stimulating behavior, terms that will be known generally only to a person in the field. [1-97]

What does that mean?

A. These are behaviors which, to the casual observer, appear to be strange and bizarre. They are rhythmic motions, such as rocking, or head-banging or the waving of one's hands in front of one's eyes.

Other forms of self-stimulatory behavior might include certain forms of self-injury, such as picking at certain parts of the body, hitting oneself, slapping oneself, and activities of this nature.

Q. Have you, in your profession, Doctor, determined what are the causes of such behavior?

A. There has been a good deal of study as to the causes of such behavior. There is general agreement that in the majority of cases these behaviors are learned, that is, the individual has been repeatedly rewarded for engaging in this behavior. Usually they are rewarded in a subtle fashion, that is, they receive attention for performing these behaviors.

It is not surprising to find that such behaviors are found in approximately two-thirds of institutionalized mentally-retarded persons.

Q. Why do you find that not surprising?

A. One of the reasons is that such behaviors are closely associated with lack of stimulation and boredom. They tend to increase as the environment gets less stimulating. It will also increase following restraint. They are associated with hunger, with loud noise, and with strange environment. [1-98]

These behaviors, by the way, are not so unusual; they are fairly common in normal human beings. If one observes passengers waiting in an air-

port when an aircraft has been delayed for several hours one can usually observe the onset of some of these sterotypic behaviors. Individuals will start yanking at an ear or rubbing a nose or engaging in these kinds of behavior and they appear quite quickly under such conditions.

They were also observable in zoos, particularly among the higher apes — the chimpanzees and the gorillas, particularly unfortunate if they live in barren cages. One can then observe them engaging in very similar behavior to some of these retarded individuals.

Q. Would you then, in your experience, attribute some of this behavior that you have described to institutionalization?

A. Yes.

Q. Are all institutions equally good or equally bad in your experience?

A. No. There are very significant differences among institutions.

Q. What kinds of differences are you talking about?

A. The impact of the institutions varies on their efforts. There have been some comparative studies
[1-99] among institutions which suggest that in some institutions the behavior of the residents is markedly different from the behavior of residents in other institutions.

It appears that this is to a great extent a function of the amount of human contacts which the institutionalized resident has, particularly with professionals and volunteers on the living unit. The presence of educational programs and of early and intensive intervention has also been an important variable, as has the size of the institution and of the living units. In general, individuals who live on small living units and in smaller institutions show a higher level of behavior.

Q. Do you have any studies of these findings that are landmarks in the field?

A. Mark Klaber in Connecticut, as I recall, made some very interesting studies relating the level of behavior primarily to the degree of contact.

* * *

BY MR. THRASHER:

Q. Does Skadak sometimes publish under the name of Marie Christie Skadak?

A. That is correct. That is her later name, probably as a result of a marriage some time later in life.

Without going into details, these individuals studied orphans raised in an orphanage environment and studied other individuals who were raised in a somewhat impersonal manner and similar individuals who were raised by normal young women who served as mother-surrogates and they compared these individuals in later life and they found that at the end of a number of years those who had been raised by the mentally-retarded mother-surrogate had gained an average of twenty-three and a half IQ points; the other orphans who were raised in an impersonalized institutional environment had lost an average of 26.2 IQ points, an extremely significant finding.

Q. Have you determined that some institutions are more destructive than others?

[1-101] A. Without a doubt.

Q. Have you determined as to those institutions which you would characterize as to being destructive what the causes are?

A. The causes are many.

One of the prevailing ones is lack of inter-personal intimacy — the inability of the residents to model, that is, to emulate adults and to pattern their own selves after these adults.

Another characteristic of these institutions is a lack of consistent social rewards, that is, the individuals are not consistently rewarded for behaving in approved social fashion.,

Another characteristic is pervasive social and sensory deprivation. In the poor institution the environment is not stimulating.

BY THE COURT:

Q. May I interrupt to go back and take you back about two questions?

A. Yes, sir.

Q. You referred to the mother-surrogate.

A. Yes, sir.

Q. Would you explain what you mean by that?

A. Yes. I meant by that that each of the orphan children was assigned to one individual young retarded
[1-102] woman who served as if they were the mother of that particular orphan, giving that child the personal attention and consistent human contact.

Q. Was there any particular significance to the fact that the mother-surrogate was also retarded?

A. No, I don't think so. The important thing was that there was a consistent human relationship.

Q. I see.

A. Some individuals have pointed to the study as indicating that mentally-retarded women can make adequate parents; but this was not the nature of the study.

* * *

BY MR. THRASHER:

Q. Doctor, you were testifying about the destructive effects of some institutions and the causes for that.

A. Oh, yes. The problems of sensory deprivation, of living in barren, non-stimulating environment.

There is, of course a wealth of research regarding the impact of sensory deprivation on normal human beings and we know that if a normal human being is deprived even for short periods of time of sensory input the individual is likely to develop strange, bizarre behavior, including psychotic symptoms such as hallucinations, delusions, distortions of the body; in short, the kinds of behavior that are typically associated with schizophrenia.

[1-103]

There is also a great deal of research using animals, in which animals have been deprived of sensory stimulation, of sensory input; and although many species have been used, including dogs, chimps, Rhesus monkeys and others, the effects are pretty much the same in that they will show a marked deficit not only in behavior but in actual physiology.

There appear to be disturbances of deterioration, if you would, of the sensory-motor system and of the brain itself.

* * *

[1-105] BY MR. THRASHER:

Q. Doctor, your testimony is that you have stated that there is a recent trend in the treatment of mental retardation.

Will you summarize your view of the recent trend?

A. Yes. I think I can do so.

I would first refer to what we speak of as the developmental model of mental retardation. By this we mean essentially that retarded individuals should be approached with the assumption that they are capable of growth, of development, of learning; that the environment which we provide for them has a major impact in determination of the rate of this development, indeed, that the human organism is highly

[1-106]

plastic and is in continual interchange with our environment.

Specifically, we propose — "we" being myself and two colleagues who first developed this model some years ago — that environment should be designed to increase the complexity of the behavior of the developing individual to increase his capacity to cope with his total environment and to enhance its human qualities as these are defined by the world in which we live.

Since then that model has been used extensively and I understand in various national standards.

Q. In comparing the mentally-retarded person with the non-retarded person, would you characterize the mentally-retarded person as being more similar to non-retarded persons or more different than they are?

A. Well, this pretty well addresses itself to another major trend in that in the past we tended to emphasize differences and we put a great deal of emphasis on labeling and stigmatizing; in short, a generating self-fulfilling prophecy.

Recently, we have adopted a basic principle referred to as a normalization principle or principle of normalization, which is just simply to suggest that we should treat the handicapped person as much
[1-107] like the normal person as possible; that, unfortunately, we have tended to foster and generate deviancy by treating people as if they were different, by isolating them and segregating them from Society.

Q. Would you characterize that as the principle of normalization?

A. Yes.

Q. Doctor, in your experience, has normalization, as such, been applied within institutions?

A. Yes. It has been applied in a lot of institutional services, particularly by Wolfensberger. Basically,

he developed a number of concepts of typing the principles specifically to institutions. For example, he said that residential services for retarded persons should be integrated with Society in general; the services should be dispersed throughout the community so as to facilitate assimilation of the individuals.

Secondly, that residential services should be small, small and dispersed because lots of institutions, he pointed out, tend to lead to dehumanized forms of management and they form their own subculture and cause them to lose contact with a wide society.

* * *

[1-111] Q. Now, Doctor, turning more specifically to the institution which is at the issue of this case, as I recall, you had an opportunity to tour Pennhurst two separate times — once in 1975 and once in 1977; is that correct?

A. Yes, sir; that is correct.

Q. Could you summarize for the Court, if you will, please, your *modus operandi* when you took those tours?

A. Yes. I conducted a number of separate interviews with staff at all levels of the institutional hierarchy.

I reviewed —

THE COURT: May I interrupt you with one question?

BY THE COURT:

Q. When did you do this?

A. Yes, sir. April 7th and April 8th in 1975 and February 28th and March 1st in 1977.

THE COURT: Yes. You may proceed.

BY MR. THRASHER:

Q. Will you describe how you went about the survey, Doctor?

A. All right.

In addition to the subject interviews I reviewed records and various other materials and exhibits
[1-112] and I toured the facilities.

Q. Now taking you back to your first survey in April of 1975, did you determine that the institution provided all of its residents with minimally-acceptable services?

A. Yes.

Q. You did so determine?

A. I made a determination and I concluded that it did not.

Q. Did you make a similar determination at the conclusion of your second visit?

A. Yes.

Q. And what was your determination at that time?

A. That the institution did not meet these basic requirements.

Q. I presume from my familiarity with the case that you found some evidence of improvement over a two-year period; is that correct?

A. That's correct.

Q. Would you tell the Court what improvements you found?

A. Yes. I will try and summarize the major improvements which I observed.

First, I should comment on improvements in the physical environment for some of the residents. A number of the older and less-suitable buildings had been phased out at the time of my second visit and some had undergone some degree of renovation.

Q. Do you, Doctor, conclude that the improve-
[1-115] ments that you just summarized represent a major change for the residents of Pennhurst?

A. No, I would not consider it.
Q. Why is that?
A. The big problem is that large numbers of residents were still not adequately served. There was, I felt, a marked lack of program for a very significant number of Pennhurst residents.
Q. "Program" is a term you have used several times in your testimony.

What do you mean here when you use "program"?
A. By "program" I mean a formalized plan for individual training, habilitation, and treatment.

That's essentially the guideline which is to be developed, implemented, monitored and evaluated by a multi-disciplinary team, a team which includes the residents themselves and/or his parent or guardian.
Q. Do you have an idea, Doctor, as to the basic concepts that should be included in the program?
A. Yes. I would essentially consider the following the essential components of such a program?

First, a [personal] evaluation, which should include the strengths, the weaknesses, and the technical needs of the individual. [1-116]

Second, a listing of both short and long-term objectives, which again needs to be highly individualized and specific, respecting measurable and observable dimensions.

Next, specific effective procedures which are to be used to accomplish these objectives.

Ongoing monitoring regarding the progress made toward reaching the objective.

Periodic review-evaluation of the individual using objective measures of progress.

And finally, modification of the objectives and/or of the methods used to reflect the findings from the evaluation.

Now such a plan, often thought of as an individual program plan as previously mentioned, needs to be recorded, written understandably, so that it can be understood by relatively unsophisticated individuals. It needs to include the specifics and it needs to be readily available to all persons involved in the implementation.

MR. THRASHER: May I approach the witness, your Honor?

THE COURT: Yes.

BY MR. THRASHER:

[1-117] Q. Dr. Roos, I now hand you U. S. Exhibit 43, which is identified as "Standards for Residential Facilities for the Mentally Retarded, Joint Commission on Accreditation of Hospitals," and ask you if you are familiar with that document.

A. Yes, I am familiar with it.

THE COURT: What's the name of that document again?

MR. THRASHER: It is the Joint Commission Standards for Residential Facilities for Mentally Retarded, U. S. Exhibit 43.

BY MR. THRASHER:

Q. Is that the publication that you have testified about as being readily available?

A. Yes. That is the publication which encompasses the national standards of the Joint Commission.

Q. Okay.

And the ingredients of the individualized treatment program that you just testified about — will they be found in those standards similarly, as you have testified?

A. They will be delineated in this document pretty much in line with what I have just described.

* * *

[1-118] Q. . . .

Would you assign any degree of importance to these individual treatment plans?

A. I consider them essential. They are the crux of the whole habilitation effort.

Q. Why do you conclude that?

A. They are the basic blueprints for coordinating the efforts of the various individuals who are involved in habilitation.

They also are the basic evaluations too whereby one can determine the degree of effectiveness of any program.

Q. Do the present treatment plans as you envision them, Doctor, include information concerning a lot of different areas of the residents?

A. Yes. They should be comprehensive and include all areas designed to meet an individual's needs.

Q. Would the persons who would compile such treatment plans therefore come from a variety of backgrounds and expertise?

A. Typically they would. We speak of them as a multi-disciplinary team or inter-disciplinary team and they do include an expert from the various disciplines that are relevant to the particular needs of the individuals, as well as the individual himself, if at all possible, certainly, his parent or parent-surrogate.

[1-119]

Q. What disciplines would you anticipate would be required to prepare and prosecute such a plan?

A. In general, you would expect it to include a specialist in education, a specialist in psychology, a specialist in social work, plus a representative of certainly the direct-care staff who are extremely important in this effort; often, a representative of the medical profession and then various specialists, depending on the unique needs of the individual, which might include physical therapist, occupational therapist, recreational therapist — individuals of this nature.

Q. Doctor, do you conclude that the residents of Pennhurst are adequately programmed?
A. No. My conclusion is they are not.
Q. On what basis do you reach that conclusion?
A. Well, the superintendent of the institution, for example, told me that the adults at the institution receive an average of one and a half hours of programming a day.

I noticed during his deposition he testified that some 500 residents are not receiving what be considered to be minimally-acceptable care and treatment.

Q. What would you consider to be minimally-adequate programming time on a *per diem* basis?
[1-120]
A. I would say probably a minimum of six hours a day during the five weekdays and then appropriate recreation and leisure time and this type of activity on the weekend.

Referring to the standards that are being produced, one of the standards therein states specifically that activities scheduled shall not permit dead time of unscheduled activity of more than one hour continuous duration.
Q. In addition to the information given to you by the superintendent — was that Dr. Youngberg, incidentally?
A. Yes.
Q. — did you find any other evidence of a lack of adequate programming at Pennhurst?
A. The direct observation of many of the living units revealed a great deal of aimless activity, of what I call enforced idleness, people lying on the floor, milling about, sitting, staring into space, and so forth.
Q. Do you recall the wards you went on with the requisite specificity to give some examples?
A. I have made some notes on some of the specific units to which I would need to refer to do that.

Unit 47 — a lot of aimless wandering about; no observed activity. There was no staff present with ten residents in the day room. This was at 2:40 in the afternoon.

On Unit 49 — a large group of men sitting
[1-121] about or lying on the floor. It was a little after three in the afternoon.

MR. GOLDBERG: Excuse me, your Honor.

I might interrupt to say I don't know when these observations were made. There were two studies made here.

THE COURT: All right.

BY MR. THRASHER:

Q. Doctor, you are testifying now about times and wards.

Was this on your first trip or on your second trip?

A. This was on my second trip.

Q. And the dates of your second trip?

A. February 28th and March 1st.

Q. Thank you.

Would you proceed, Doctor? You were testifying, as I recall, about Unit 47.

A. Yes. I mentioned 47 and 49.

I am going over these rather quickly, if the Court pleases, to just give a sampling of the kind of observed activities.

On Unit C-9 I observed a large number of women sitting about, many of them in wheelchairs, and I observed no organized activities, which was at 3:20 in the afternoon.

On Unit M-3 men were sitting in a small day
[1-122] room; several were lying on the floor.

I asked about what programs were going on there and I was told that the only programming operation was a so-called showering program, although there was only a single shower available on the unit.

Q. How many residents lived on the unit, Doctor?
A. I'd have to look that up on the record. I don't recall.

On Unit 48 I saw a large group of men in two day rooms. I observed no interaction between staff and residents; the residents were aimlessly milling about.

On Unit K-32, which held thirty-five women, I found these women either lying on mats or sitting about.

These were the kinds of activities that were common throughout the institution.

BY THE COURT:

Q. Let me interrupt to ask you, for instance, what type of programs would you have expected to find in those particular locations that you visited?

A. Yes. Although I might later go into some of the technology, what I would expect to find is active interaction between the staff and the residents. I would expect the residents to be in small groups, working intensively with staff in specific habilitation or training activities.

This might, for example, include development of basic self-help skills, dressing skills, grooming skills.

[1-123] Then I would expect the development of some communications schedules — the staff teaching lessons how to communicate, both at the non-verbal level and then at the verbal level; the development of receptive language so they would be, for example, able to recognize objects and communicate their basic wants and needs.

I would expect some activities designed to teach residents to interact with each other in social life. In short, rather than simply warehousing the residents I would expect certain activities to be go-

ing on designed to foster the individuals' development.

* * *

BY MR. THRASHER:

Q. You testified about certain indicia in your judgment as to a lack of programming, Dr. Roos.

Did you find others?

A. Well, in addition to the direct observation I also reviewed files on specific residents and I found that
[1-124] for many of these the programmatic concept of the files was either sparse or non-existent.

In addition, I found discrepancies between what the records suggested was taking effect and what, in effect, was taking place.

Q. When you noticed these discrepancies did you note some examples?

A. Well, on A-2 I looked up the file of a specific resident.

Your Honor, do you want the number identifying these residents?

Q. An identification number will be fine.

BY THE COURT:

Q. That's a number rather than a name?

A. Yes.

Q. Yes. You may use that.

A. This was Number 6636. In reviewing the file I found no indication that there had been any development or review of programs for several months.

I also found a lack of a daily program schedule or any individual objective for this individual.

BY MR. THRASHER:

Q. Doctor, before you go on to some other examples, what would you have expected to find to indicate the input into that file that you have described?

A. I would have expected to find specific objectives
[1-125] for the individual, listing specific procedures to be

used; an indication of who was to use these procedures; and how the progress toward the objective was to be quantified.

Furthermore, I would expect to find a daily activity schedule for that individual outlining the specific activities that he was to participate in at specific times during the day.

Q. I take it, so there will be some enforceability of the program and accountability?

A. Exactly, specific outlines and specific accountability.

* * *

[1-126] Q. Do you have an example for Resident Number 8769?

A. Yes, I do. I reviewed that file on Q Building and I found that a program in "bedmaking skills" had been initiated in November of 1975 and I could find no further indication as to what had happened to the program or the individual's participation in the program.

I then asked the staff there if they could explain to me what was going on; and they were unable to describe the individual's learning program.

Looking further, I found that the latest behavior-modification program for this individual was dated October 6, 1975; the latest psychological report had been completed April 4, 1974.

Now I also noted that this was an individual who allegedly manifested aggressive behavior and attacks and there were repeated references to the use of restraints and seclusion.

[1-127] Q. Doctor, in your earlier testimony you touched on various modalities of treatment for mentally-retarded persons, one of which was behavior modification.

Would you please describe to the Court what is behavior modification?

A. Yes. Behavior modification is a very widely used technique today. It is also known as contingency management or behavior shaping.

It is essentially the systematic application of learning principles, primarily the work of B.F. Skinner, S-k-i-n-n-e-r, technically known as operant conditioning.

Essentially, it is the application of some very simple principles, namely, that behavior is strengthened when it is followed by a reward or a positive reinforcement. On the other hand, behavior is weakened when it is followed by an unpleasant consequence, technically known as a negative reinforcement.

Behavior results are weakened when it is followed by nothing. Technically, this is known as extinction of behavior.

There are many types of events which are rewarding to human beings and which can be used very successfully to develop behavior. There are usually both types of rewards that are commonly recognized.

The first of these is intrinsic rewards and this
[1-128] refers to activity which is pleasurable in and of itself; playing tennis or swimming would be examples for most individuals.

The second type of reward is the so-called social reward and that is essentially approval by another human being, which is highly potent for some individuals but not for everyone.

Artificial reward refers to such things as money to tokens. The use of tokens has been very prevalent in many institutional programs.

Then finally there are the so-called repetitive rewards which refer to those rewards which fill what are your basic biological needs, such as food and drink.

The important thing in the use of rewards is that they must be individualized and periodically evaluated because something that turns a person on today may no longer turn him on a week from now, a month from now. You may satiate a patient with a reward.

Now there are a number of basic principles in applying behavior modification which are generally recognized, which have been described in detail in the literature and unless the Court is specifically interested in these I will just indicate that they are well-established.

Q. What is the importance, Doctor — it may not be clear to everyone, but what is the relevance or im-
[1-129] portance of behavior modification to the condition of mental retardation?

A. It is probably the most effective technology available today. It is particularly useful with retarded persons because many retarded persons are non-verbal.

In the past techniques have relied primarily on spoken language, in schoolrooms, in psychotherapy, and everything else.

Many psychiatrists dealing with retarded persons do not have language. Behavior modification then is a technique which is particularly successful with non-verbal individuals. It is a sympathetic technique which can also, therefore, be applied by individuals who are relatively untrained — direct-care staff, parents, and other individuals under the proper supervision and guidance can apply these techniques.

The techniques are applicable to individuals, but they can also be applied to groups of individuals with relative ease.

Q. I take it from your earlier testimony that the condition of mental retardation itself is primarily identified by the aberrant behavior of persons as opposed to those exhibiting normal behavior?

A. No, I would not say that.
Q. How would you describe then behavior fits into the definition of mental retardation?
[1-130] A. I would say that the basic problem, of course, is in the area of learning; that most retarded persons will not manifest aberrant behavior, but rather will manifest deficits in behavior, a lack of skills, a difficulty in acquiring skills or taking longer to acquire skills.

The aberrant aspects of behavior seem to be a part of the environment in things which are learned in it and are not learned in the inherent aspects of mental retardation.
Q. Would you define [behavior] modification psychiatry such as you have described in Pennhurst?
A. I did find such techniques in use on a number of the units. I was surprised, however, to find that they had been abandoned on a number of units.

Specifically, for example, on M-3, where a token economy is in operation, I was told that it had been abandoned some two years ago and that no substitute program had been instituted.

I also found on Unit Q-1 that a token economy had been abandoned allegedly because of the staff's inability to obtain proper reinforcers, that is, they couldn't obtain the proper kind of things to reward the residents on this unit. I found this was particularly unfortunate because this unit was supposed to have an expensive habilitation unit designed specifically for individuals who are manifesting aberrant forms of behavior.
[1-131] Q. Did you determine why, in your opinion, the procedures that you have described at Pennhurst were not effective?
A. Well, it was apparent to me that in some of the units the staff, the direct-care staff themselves, seemed unfamiliar with the procedures or not properly motivated to use them.

I also found that an intensive training unit, such as Q-1 is supposed to be, which was designed to apply the technology intensively to residents so that they could be returned to their basic living units, was not having that effect and that, indeed, there was very little turnover on that unit, so that residents stayed there literally for years.

So that —

Q. Excuse me. Did I interrupt you, Doctor?

A. I was just going to say so that the unit was really no longer an intense habilitation unit. It just became a dead end appparently.

Q. Okay.

Would you describe Unit Q-1 as compared to the units that such persons would have returned to had it been effective?

In other words, was it more restrictive than the other wards?

A. I am told it was more restrictive than the other wards and less stimulating in general.

[1-132] Q. How was it more restrictive?

A. It was a very barren place. There is a place called the day room with no furniture in it at all; just bare floor and bare wall.

I think that there was one basketball baskethoop upon the wall.

Then, as I recall, there was a sort of a large bedroom area in which the beds were just sitting one right next to the other. I don't recall seeing any curtains or drapes or decorations other than some painting on the walls themselves.

There is also a seclusion room in that unit.

Q. Would you describe what a seclusion room is, Doctor?

A. Well, of course, seclusion rooms differ considerably. This particular room was a fairly large room with a very high ceiling.

It was dark in there, as I recall. A heavy door with a little opening in the door and at the top of the room, near the ceiling, there were some pipes. I assume they carry water, steam, or some such thing.

Q. Were the walls and floors padded or where they hard?

A. I don't recall any padding. This was all hard.

BY THE COURT:

Q. What do you mean by a seclusion room?

A. Essentially by "seclusion room" I mean a room
[1-133] where an individual is kept by himself with the door closed and he is kept there, segregated from the rest of the living space, for a period of time.

BY MR. THRASHER:

Q. Did you find that Q-1 was a locked ward?

A. As I recall, it was.

Q. That is, the residents aren't free to leave the ward?

A. Yes.

Q. You mentioned seclusion, Doctor.

Did you find at Pennhurst the use of restraints and seclusion?

A. Yes. I found both were common.

Q. Do you recall any example that you saw on your tour? I take it this is the most recent tour in 1977?

A. Yes.

Q. Will you give some examples, please?

A. On Unit H-2, I noticed Resident 6636. The record indicated that seclusion was used with this individual on a PRN basis, which means as needed, apparently during twelve-hour periods.

In addition, this individual was in restraint and was receiving heavy medication.

On Q-1, I have already referred to the seclusion room there. I found that Case Number 8769 showed frequently placement in seclusion.

[1-134] I did visit that particular seclusion room and I found feces on the ceiling of that room and a bunch of old clothing hanging on those pipes which I have described near the ceiling of that room.

I was told by the staff that this room was cleaned every other day.

I noticed from the superintendent's deposition that there are five or six seclusion rooms scattered throughout the institution.

Q. Doctor, you mentioned PRN.

In your experience what is the purpose of PRN orders?

A. Well, when you get to seclusion, this is essentially the direct-care-staff, an open door putting the individual in the seclusion room at any time they see fit.

Q. Did you see any other examples of restraint?

A. Yes. I saw quite a few restraints in use. In Q-1, Case 8769, there was a leather band. The hands were being pinioned in this fashion.

Case 9001, likewise in these bands. On Ward 1 of the hospital, an individual tied by both wrists to a wheelchair. I saw several tied in their bed, either by the wrists or by the ankles.

On Unit C-9, an individual was tied in bed by the wrists and the ankles both.

[1-135] On Unit H-2 I saw an individual in leather muffs.

These are some of the specific instances which I made a record of.

Q. In viewing the use of seclusion and restraints as you described, what do you conclude as concerns Pennhurst?

A. It suggests to me first that it is simply improper and/or inadequate programming. These are symptomatic of individuals just not receiving the services they need.

In addition, of course, I considered the use of such techniques as highly dehumanizing. One of the real problems when you incapacitate individuals is that this precludes their learning and hence precludes their development. You are essentially condemning the individual to a lifetime of confinement.

Furthermore, evidence suggests that the use of this technique tends to increase the tendency toward self-stimulation, self-destructiveness, stereotomy, and other behaviors. That is the very cause of the behavior which it is designed to eliminate.

Q. Doctor, in your opinion do you feel that seclusion is acceptable?

A. Well, the standards here, the blue book, say there specifically that seclusion defined as the placement of a resident alone in a locked room shall not be employed. That is categorically stated there — should not be, shall not be.

Now I feel that generally this is correct. I would make one exception, and that is the use of a technique known as seclusion time out, which is a very specific technique incorporated in a total regime of behavior modification.

I can see it as acceptable under specific conditions.

Q. Did you find those conditions extant as to Pennhurst?

A. No, no, I didn't.

Q. Did you find indications that residents had been placed in seclusion, that is, in a solitary room with a locked door, for a period of time?

A. Yes.

Q. Do you recall approximately how long periods of time?

A. As I recall from looking at various records, some

individuals were placed in seclusion for many hours over a period of years.

Q. Do you find that an acceptable habilitative treatment?

A. I find it totally unacceptable.

* * *

[1-139] BY MR. THRASHER:

Q. Doctor, we were covering the practice of seclusion and I believe I had asked you whether or not seclusion was an acceptable practice and you had defined it as a practice of seclusion which was very limited in form.

Now that was in regard to the way of addressing certain behavior. What do you consider to be effective and acceptable procedures for addressing a hypothetical question and eliminating undesirable behavior patterns of mentally-retarded persons?

A. Beginning with the basic assumption of undesirable behavior alone and untainted by the environment, obviously, the first approach to eliminating them is to minimize those factors which cause such behavior in the first place, that is, boredom, inactivity, frustration, harassment, and so forth.

[1-140] In addition, now, specific techniques are designed to weaken undesirable response. A number of these consist primarily of systematically rewarding desirable behavior and ignoring undesirable behavior.

To implement these techniques requires the coordination of all individuals interacting with the client so that consistency is maintained.

If one individual rewards an undesirable behavior this would immediately and consequently undermine the total program.

In addition, specific techniques have been developed, particularly by Nat Agrin, A-g-r-i-n, which

are designed to deal effectively with particularly noxious behaviors which cannot be simply ignored.

An example of this is what we call the technique of contingent observation. Let me use it as an example of design.

Assume for a moment that there are several persons engaged in a training activity and then one of these individuals becomes highly destructive. He will then be removed quietly from the group and asked to sit in a chair and asked to observe what the other individuals are doing for a relatively brief period of time.

When he has quieted down and has regained
[1-141] attention he is then returned to the group.

An analogy to this is the people-block game, when an individual is put in the box and asked to observe the game on a contingent basis.

* * *

[1-143] BY MR. THRASHER:

Q. Dr. Roos, did you find that the procedures to address destructive behavior were effectively employed at Pennhurst?

A. No. I felt they were not.

One of the basic problems is that the environment itself is in many cases not rewarding, not reinforcing; so that being drawn from it may, in point of fact, be perceived as a reward rather than the taking away of a reward.

The lack of activity, the lack of systematic program, makes it very difficult to apply these techniques effectively.

Indeed, it is quite probable that the situation frequently strengthens negative behaviors because they are the behaviors which tend to get the attention of the staff.

Q. Did you find an adequate monitoring system on such procedures at Pennhurst?
A. Generally, I found there were no adequate monitoring procedures.
Q. Are there standards available —
[1-144] A. Yes.
Q. — to establish guidelines for such monitoring?
A. Yes. There are effective techniques, specific guidelines have been developed both by the American Association of Mental Deficiency and our own association has published guidelines specific to the monitoring of behavior-modification programs.

These guidelines require review, ongoing review by a professional review committee as well as by the Human Rights Review Committee.
Q. Do you feel that Pennhurst has adequate monitoring methods?
A. Unfortunately, I feel this is one of the areas in which the institution has made only slight progress, very little progress, during the few years.
Q. Do you have in mind some examples that were lacking in this regard at Pennhurst?
A. The superintendent told me at the time of my second visit that there was no formal statement on the residents' discipline. He indicated that a policy on abuse was not yet operational, that it was not yet — it was being evaluated and he, himself, felt it was too lenient because it defined three degrees of abuse.
Q. Let me interrupt you there.

What is a policy on abuse? What does that mean?
[1-145] A. In terms of his description of it I would assume what he was referring to was a policy which he would push with regard to employee abuse of residents.

[1-146] Q. Did you determine whether or not, Doctor, there were any what the Commonwealth referred to as advocacy programs?

A. No. Again, at the time of my first visit there was discussion of the institution's attempt to develop an advocacy program.

By the time of my second visit, little or no progress had been made. I was told by the superintendent that there were only three to five residents involved in such a program and the superintendent said himself that the program is very, very limited.

Q. And what is the advocacy program?

A. The program that we were discussing is essentially a citizen-advocacy type of program in which interested citizens volunteer to serve on a one-to-one basis in relating to a protege, that is, an individual mentally-retarded person; and third that that individual stands as a father-advocate and looks after the individual's human rights as well as emotional needs.

THE COURT: May I just interrupt there and ask a question?

[1-147] BY THE COURT:

Q. This was along the line of the grandparents program that you said the Federal Government was sponsoring?

A. It is to some extent. Both programs give some emotional support to the residents.

Q. I was going to ask you at that time, but I will ask you now — in connection with Pennhurst, why could not the patients' own relatives serve in that capacity?

Of course, I recognize that there may be some that don't have relatives that are interested, but in view of the statement made this morning, which is certainly not true for all of them — now why couldn't that be included? Why wouldn't that be a

more effective recommendation that the child's of the person's own parents or close relatives assume this role and work with him?

A. That certainly is a logal approach, your Honor. A number of problems, nonetheless, occur.

First, that many residents no longer have parents; second, and it is difficult for me to say this, but to some degree parents are often reluctant to antagonize the institution. They fear, whether this is rational or not, possible retribution by the institution's staff against the child.

Having been a superintendent myself, as well as the parent of a child in an institution, I realize
[1-148] that this factor, unfortunately, is still present in some cases.

The third problem is that there may be some cases in which the parent may not be the best advocate for his own child. There may be some cases in which the interests of the parent and the interests of the child may not coincide. Hopefully, that would be infrequent but, nonetheless, it will sometimes occur.

[1-148] BY MR. THRASHER:

Q. Dr. Roos, in regard to the Judge's question and your answer, would the geographical and physical location of Pennhurst pose any problems to parents acting in the manner you just described?

A. I would suspect that the geographic distance between some of the parents and the institution would be a logistical problem.

Q. Are there other areas, Dr. Roos, in your judgment, where Pennhurst has failed to make adequate progress in the last few years?

A. Yes, definitely.

Q. Will you give us some examples, please?

A. The institution has frequent conditions which violate what you might call human dignity and respect for the individuals.

We discussed some of them and without delinating them into detail, let me mention just
[1-149] things as dehumanizing environment; toilets without doors, without partitions; toilets without toilet paper; sometimes without tile toilets; sometimes unflushed, dirty, filthy; open showers; lack of soap or towels; lack of decorations; lack of any individualization in the living area; lack of pillows on the beds — little things like that.

Residents are being forced to eat either with their fingers or with spoons with no other kind of eating utensils. Urine on the floor, feces on the ceiling — these kinds of conditions.

Indeed, in looking at the superintendent's deposition I noted that he indicated that he felt the environment did not meet minimum professional standards; and I would certainly concur in this.

Other considerations — the clothing for many of the residents is ill-fitting. It is obviously institutional in nature.

On a number of units I found residents in partial states of nudity. On some they had no shoes — bare feet — and things of this kind.

A lack of privacy is general throughout the institution. In many areas they sleep in open sleeping areas, no drapes or curtains on the windows, no quiet place where an individual can withdraw for a certain period of loneliness; usually large groupings, frequently loud music, and all blaring
[1-150] television sets; lack of provisions for any personal property.

These kinds of conditions are characteristic.

Q. Would you describe the conditions that you just testified about as creating a home-like environment?

A. Quite the opposite. They are unlike any home. Even the rhythm of life is often at a marked deviance from what we experience.

I was shocked to find, for example, on one living unit that the individuals eat supper at four-thirty in the afternoon and that the nurse from the unit spontaneously commented that the residents get extremely hungry and they are disturbed as a result of this schedule.

These people are put to bed at nine-thirty and the entire rhythm of the day is at variance with the normal.

Q. Is that done for adults?

A. Yes, this was an adult group.

Q. Do you have any opinion, Dr. Roos, as to the impact such conditions and environment would have on mentally-retarded residents?

A. I feel that the impact would be highly detrimental to these individuals. Obviously, these conditions violate the basic principles which I mentioned this morning. They foster deviancy. They violate our
[1-151] concept of normalization and developmental programming.

Indeed, these conditions are likely to cause regression and deterioration rather than development — deterioration both psychologically and physically. They are liable to foster pathological behaviors of all types and I will outline some of these.

It certainly violates attempts at individualization. Regimentation prevails and many of these people are robbed of their individuality.

And when it comes to self-actualization the type of environment and conditions I have described tend to foster compliance and eliminate the possibility of decision-making.

Q. Doctor, you mentioned regressing.

Could you tell the Court what that means?

A. By regressing we mean essentially the behavior becomes increasingly more primitive, that is, more childlike, less mature, less sophisticated.

* * *

BY THE COURT:

Q. How many residents were there at this time when you were visiting, if you know, when the staff was 1,560?

A. As I recall, at one time that I visited there were somewhere over 1200 residents.

Q. 1200 residents?

A. . . .

[1-153] Now, in addition, and I am particularly concerned about this, there seems to be a decrease in the number of professional positions.

BY MR. THRASHER:

Q. Would you define professional positions, Doctor?

A. We are talking essentially about educators, social workers, psychologists, physicians — people of this nature.

What seems to be happening is that as a professional person leaves the staff that position is changed into a direct care position and instead of being able to recruit a like professional the institution is able to recruit a direct-care staff person.

The result of this is that the professional services division has lost nineteen professional positions in the last two years. For example, psychologists have decreased from twenty-three to nineteen and the persons in the development of program tech-

[1-154] niques have decreased from seventeen to thirteen and so on.

One of the things that's obvious, as you look at the situation, is that there are long waiting lists within the institution of residents being referred to specific services by the program team, but not being received by these services because of lack of staff.

Q. Does that mean, Doctor, that you described a group of residents who are already admitted to Pennhurst and whose needs have been defined at

Pennhurst and whose needs even as so defined Pennhurst cannot meet?

A. That's exactly the case, yes.

Q. Did you, in your tour of Pennhurst in 1977, observe any areas or wards where there were not staff present?

A. I made note of one particular group, housing for profoundly-retarded individuals, where there were no staff present at the time of my visit here.

* * *

[1-155] Q. Do you know of any impact on the residents of the buildings from the staff?

A. Yes. There tends to be a lack of coordination and effort to erase any gap between the plans as reflected on paper and the implementation of these plans when you observe what is actually taking place on the living units.

Q. Okay.

Are the attitudes and roles that the staff assume vis-a-vis mentally-retarded residents important?

A. Extremely important.

Q. What roles should staff members play as com-

[1-156] pared to their services to mentally-retarded residents?

A. It depends, of course, on the particular staff. The main care of the direct-care staff is with the residents many hours a day. Traditionally, these individuals tend to consider themselves as custodians and house custodians.

The feeling today is that they should essentially be trainers, socializers, and that they need to make a shift if they are truly to be helpful for the residents.

* * *

[1-158] BY MR. THRASHER:

Q. Now, Doctor, the conditions that you have testified about at Pennhurst, do you feel what you observed was essentially hazardous to the residents?

A. Yes. I feel the conditions are potentially hazardous psychologically.

Q. Could you give us some specific examples, please?

A. Being brief, if I may, your Honor, I would emphasize these situations:

First, filth. I observed excrement, urine, dirt, mops strewn about, pools of water on the floor, piles of clothing scattered about, and things of that nature.

Secondly, the toilet areas. Particularly disturbing is an almost universal lack of toilet paper on the units which I observed; no towels, no soap, unflushed toilets, toilets without seats — conditions which violate the very basic principles of hygiene.

Third, I was impressed by injuries suffered by the residents. On my tour I observed some of these injuries — a bleeding gash over the eye of one residents, bad patches on the leg of a woman.

In reviewing the superintendent's deposition I noticed that he reported 833 minor injuries and 25 major injuries during the month of January 1977. That's during a single month.

[1-159] As I indicated too, there seems to be a lack of supervision. In some of the units there may be very few or in some instances no staff present.

Feeding practices — I felt they were at times quite tenable.

MR. GOLDBERG: Your Honor, this seems to be rather repetitive. This has already been stated by the witness in his previous testimony.

THE COURT: This is the first time I have heard this.

BY THE COURT:

Q. You may proceed.

A. Well, I think that the feeding practices — I did observe, for example, in one dining area, an attendant feeding a resident much too rapidly, shoving

food into that resident's mouth, which, of course, has some potential danger of implications for that resident.

BY MR. THRASHER:

Q. Is that manner of feeding particularly dangerous in a mentally-retarded population?

A. There is an added danger in the retarded population, particularly individuals who are severely and profoundly retarded. There is a danger of pneumonia, there is a danger of lack of nourishment, and the individuals may not be able to indicate that they are being fed too rapidly.

* * *

[1-160] BY THE COURT:

Q. Let me ask you a question, Doctor,

In your summary of the conditions just how that you mentioned as having been in your opinion, or I will put it this way, conditions that are hazardous to the residents, I think the last one you referred to was the feeding practices.

Do you have any information that you obtained from Pennhurst as to how many of the residents have to be fed by hand in the instance that you just described?

[1-161] A. I do not your Honor. I think the data are available but I do not recall seeing them myself.

Q. Generally, let me ask you this as an expert — in an institution that is housing retarded persons, what percentage of them would you expect to find that required individual feeding?

A. It would depend on basically two variables — one, the level of the retardation of these individuals. I would generally expect that very young individuals would need such help; seriously ill individuals during the period of the illness, or profoundly-retarded individuals.

Now the second variable is the amount of training.

We know that even profoundly retarded individuals seem to feed themselves unless there is a neurological or motor problem.

Q. Would one conclude from what you have just stated that the problem of feeding by hand a resident would be a very small percentage of the population then?

A. I would say that's very correct, your Honor, if training programs are in operation.

* * *

[1-162] BY MR. THRASHER:

Q. Dr. Roos, I draw your attention to U. S. Exhibit 15. As you have heard, undoubtedly, there is no reason for the names of persons to be used in the testimony if you see them through the ink.

I ask you if you have had opportunities to review that exhibit in the past.

A. Yes.

Q. Would you describe what it is?

[1-163] A. It is a cumulative accident summary. It is dated 12-29-76 to 1-29-77.

Q. What does that show?

A. It shows a long list of accidents.

Q. Could you give some examples?

A. Well, she had an injury on the forehead, fractured finger, laceration on the left side of forehead, three sutures; laceration of occipital area, four sutures, and so on down the line; broken foot, lacerated head.

Q. Do you draw any conclusions from that information.?

A. The thing looks a little like a battlefield report. It appears that it is physically hazardous for the residents to be in the environment.

Q. I call your attention, Dr. Roos, to U. S. Exhibit 16. Can you find that, sir?
A. Yes.
Q. I ask you if you have had an opportunity to review that exhibit?
A. Yes.
Q. Can you describe to the Court what the document is, please?
A. Well, it is a request for the erection of a protective fence.
Q. What's the name of the department?
A. There are several of these. The one I am looking
[1-164] at is the July 16, 1974. Then there is one July 30, 1974; February 14, 1975; February 27, 1975; and March 4th of 1975.
Q. Is there a memorandum in that exhibit which indicates the reason for the events?
A. Yes, individuals drowning in the river there near the institution, the Schuylkill River, and it lists here some nine individuals who have drowned and the memos are all designed to obtain permission to erect this fence.
Q. Now, Doctor, directing your attention to U. S. Exhibit 15, I ask you if you have had an opportunity to review that exhibit at any time?
A. Okay. Yes, I did.
Q. Will you describe to the Court generally what is in that exhibit, sir?
A. Well, very briefly, this is an accident — a special report of a situation in which one resident bit off three-quarters of the ear of another resident.
Q. When was that? When did that happen?
A. Oh, it was in January 1975; and interestingly enough the unit director's summation and recommendation strikes me because the unit director stated accident came about due to staff's having to concentrate their attention on one resident who required first-aid.

[1-165] As long as only two or even one aide is expected to provide care and supervision of residents plus custodial functions, this type of accident is unavoidable.

Q. Is there a date on that memorandum, Doctor?

A. That memorandum is dated January 8, 1975.

Q. Dr. Roos, I now hand you some stacks from U.S. Exhibit 18, Volumes 1 and 2, and ask you if you have had an opportunity to review those documents in the past.

A. Yes, I have. I have seen them.

Q. Could you tell the Court what those documents are, please?

A. Okay. The first one is a situation in which a resident slipped out of the grip of staff, or a staff person, fell on the floor, fracturing the right humerus; and a broken arm resulted, of course.

Q. Do you have any others?

A. This second one is a situation which an individual was in a wheelchair not his own, and he said there were no safety devices and the individual drug his feet, fell out of the chair, sustained laceration over the left eye and, in addition to that, a broken arm.

This was not found until twenty-four hours after the event had occurred.

Q. Now are there three other reports there?

A. Yes, there are several more.

This one — an individual slipped and broke an arm.

[1-166] I am going over these rather quickly. This is one about an individual — another fracture before and the comment of this individual is staff person says events leading to accident were all a part of daily routine. Given this accident of this nature seems unavoidable, sometimes overnight.

Q. Is that the report where the person involved was requested to pick up a table and move it?

A. Yes, yes. This individual was asked to pick up a table, stumbled under the weight of the table, and fell under another table and sustained a fracture as a result.

Q. Are there two more reports there, Doctor?

A. Yes.

All right. This is a report of an individual who was in muffs, that is, in hand restraint, and who fell as a result of that and sustained lacerations, sutures, various other stress; and the unit director stated it is my own personal opinion that putting residents in muffs is a dangerous practice. I have asked the nurses to talk to the doctor about putting residents in muffs.

There may be a little problem reading this. Anyhow, it says no results thus far. Can this matter be brought before the Safety Committee to determine alternative methods of proceeding?

[1-167] And I don't have a muff, and this was dated October 24, 1975.

Then there is the last one here. This is an individual who was placed in seclusion and who kicked the window in the seclusion room in and he sustained lacerations and contusions over various parts of the body as a result.

Q. Doctor, Exhibit 3 should be over there next to your report.

I ask you if you have had an opportunity to review that exhibit at any time.

A. Yes.

Q. Would you describe, please, what that exhibit contains?

A. Well, without going into details, this situation here is a special report dated October 6, 1976 and it has essentially an eyewitness account of a staff person raping a female resident.

Q. That is October 1976?

A. That's correct.

[1-168] Q. I now direct your attention to U.S. Exhibit 26, Doctor, and ask you again if you have had an opportunity to review that exhibit.
A. Yes.
Q. Would you tell the Court what that is about?
A. This is a situation in which an attendant beat a female resident with a shackle belt.
Q. I now direct your attention to U.S. Exhibit 37 and ask you again if you got an opportunity to review that exhibit.
A. Wait a minute. Okay.
Q. Did you find it?
A. I believe I have it. Okay.
This is a description of an attendant beating a resident with a set of keys.
Q. And what is the date of that report?
A. The first date on this is Spetember 7, 1976.
Q. Doctor, after reviewing Pennhurst and the exhibits as you have testified, are you satisfied that the interests and the welfare of the residents of Pennhurst are adequately protected?
A. No. I feel that they are not.

* * *

[1-169] Q. What pictures are those?
A. 47, 48 and 49.
Q. Now, Dr. Roos, in U.S. Exhibit 48, the picture book which is now before you, I direct your attention to Picture Number 47 and ask you if you recognize that?
A. I am sorry. Say again the number, please.
Q. 46?
A. 46, yes, I see that.
Q. Did I give you the wrong number?
A. That's all right. I recognize it.
Q. Will you describe that to the Court, please.
A. That is a bathing area and there are three men in wheelchairs, a radiator and a number of open toi-

lets; and as can be readily noted there is no type of privacy whatsoever.

Q. Would you point out to the Court what things, if any, you see to be antihabilitative or not meeting
[1-170] professional standards?

A. Well, it seems pretty obvious — I think the Court can see this — that there is absolutely no possibility for anything resembling privacy. That's a totally drab, impersonalized kind of environment.

In addition, there is some dirt lying around there and a bunch of wheelchairs sitting in the bathing area.

Q. Now I direct your attention to Photograph Number 50.

A. Yes. That's a black-and-white photograph, unfortunately, I believe, but the materials on that toilet seat are feces and there are also feces on the wall and the floor.

Q. Are they indicative of some of the conditions that you have testified about?

A. Yes.

MR. GOLDBERG: Your Honor, there is no date on any of these photographs.

Were these photographs all taken at the same time?

MR. THRASHER: Some of them were taken in 1975 and some of them in 1976.

MR. FERLEGER: For the record, I note that the table of contents, at least with my set of photographs, does list various dates.

MR. THRASHER: They are arranged in the table of contents by our expert witness, you Honor.

[1-171] THE COURT: Yes.

MR. GOLDBERG: Thank you.

BY MR. THRASHER:

Q. Dr. Roos, I direct your attention to Picture Number 54 and ask if that is an accurate representation of some of the conditions that you saw at Pennhurst.

A. Yes.
Q. Would you comment upon what that picture shows to the Court, please?
A. That is a day room, which you will notice had no furniture, no drapes; just the bare floor and walls, and that is a resident almost nude lying on the bare floor.
Q. I direct your attention now, Dr. Roos, to Picture Number 56.

You have testified earlier about residents wandering aimlessly about, and I ask you if that is an accurate representation of what you observed.
A. Yes. That's a photograph of a typical scene in the so-called day room.

If this was a moving picture rather than a still picture you would notice that many of these individuals are referring to the aeroclothinic behavior that I referred to earlier.
Q. What do you mean by that?
A. You will find that some of these individuals are rocking back and forth. Others are waving their hands in front of their heads, in a rhythmic and non-purposeful manner.

Most of these are either milling about aimlessly or engaging in these types of behavior.
Q. Now, Doctor, I direct your attention in the same exhibit to Picture Number 52.

Do you recall your testimony earlier about woman lying on mats doing nothing; and I ask you if that picture is an accurate representation of what you were testifying to.
A. Yes, that is a picture of that situation.
Q. Would you comment to the Court, please, as to what you would conclude as a professional in the field as to the caliber of the programming and habilitative activity?

A. There is no activity taking place there. This is what I described as enforced idleness.

These individuals are simply vegetating there and there seems to be no systematic activity.

Q. Doctor, I believe you have testified extensively about the dangerous conditions and the impact on residents at Pennhurst.

Are there other matters in this regard that you have similarly characterized, such as overpopulation?

A. Yes, sir, I would. I think it is fairly obvious that many of the residents at Pennhurst are living in to-

[1-173] tally unsuitable buildings, in large groupings, with lack of privacy and with obstacles to programming and development.

I notice that the superintendent in his deposition indicated that he felt between 475 and 500 residents were living in buildings which should be vacated on the basis of the Joint Commission's survey which was conducted by the institution some years ago.

There have been serious delays in remodeling and in construction as well as of the so-called new modular homes; and as a result these individuals, many of them, are still living in totally intolerable conditions.

Q. Dr. Roos, do you recall the ratio in the population between your first visit in 1975 and your second visit some two years later?

A. Yes. The superintendent informed me that the population had increased by approximately 150 during that two-year period.

Q. Was that consistent with your observation?

A. Yes. That seems to be generally in line with what I observed, as well as with the records which I saw.

* * *

[1-177] Have you reached some major conclusions concerning Pennhurst?

A. Yes, I have.

Q. Could you summarize those thoroughly for the Court, please?

A. Yes. I will be very brief. I have reached the following conclusions:

First, a significant number of residents at Pennhurst is not receiving minimally adequate treatment. Their most basic developmental needs are not being met.

Second, the conditions at Pennhurst for many are likely to foster regression, maladaptive behavior, and curtailment of mental, personal, social, and physical development.

Among these conditions I would emphasize enforced idleness, mass living and regimentation, an environment which deviates markedly from the normative.

My third major conclusion is that the physical
[1-178] plant is not well suited to developmental programming nor to normalization. The management cluster and practices are often counterproductive and work against improving services to the residents.

Thus, I feel that there exists a major discrepancy between the written documents of the institution, many of which are excellent, and observed practices. There is many times a failure of implementation, so that much of the philosophy has minimal impact on many of the residents.

Finally, I would conclude that many of the residents could be better served in less restrictive settings, using less drastic intervention and more normative approach.

Q. Doctor, I know that you have prepared some recommendations based upon your opinions and your views of Pennhurst. Some of those, I think, during your testimony were either covered fully or in part.

I would now ask for you to summarize what major remedial recommendations you might have for the Court in this area, focusing on those primarily which you have not yet testified about, if you have any.

A. I would recommend first that each and every resident of the facility receive comprehensive developmental individualized programming designed to increase the complexity of his behavior, help him to cope with his environment, and develop human qualities that he —

[1-179] I have outlined in some detail what I consider to be adequate programming and I think it might be redundant to go over these specific recommendations at this time.

Second, I feel that provisions should be made to assure that every resident has the least restrictive environment possible and the greatest possible freedom of choice — choice in dress, grooming, movements, use of free time, contact with the community, and so forth.

The staff, I feel, should prepare residents to move to more direct community living, from larger to smaller facilities, larger to small living units, from groups to individual residents, segregated facilities to facilities integrated in the community, and from dependent to independent living.

Fourth, the living conditions should be designed to approximate normative patterns to the greatest extent possible. This would include maximum grouping of no more than eight residents, privacy, personal property, storage space, and such like.

Clothing that is normative, grouping that is normative, attractive and comfortable living facilities, which are air-conditioned, with rugs, drapes, stuffed furniture, and so forth.

[1-180] Accessible toilets with toilet paper, towels, soap, partitions; adequate showers, a rhythm of life which approximates the normative patterns of living.

Access to such appropriate toys and equipment, normative eating patterns, restriction to canceled and improved and as much freedom of movement as is possible.

Next, I would suggest procedures should be established and implemented to protect all residents from abusive and dangerous practices. This would include a direct review with an opportunity for appeal to a human rights advocacy committee.

Due process procedures regarding the use of the behavior modification program, seclusion time-outs, and restraint.

The establishment of an ombudsman at the institution; and finally, the use of exit interviewers with staff on leaving the institution.

Q. Doctor, are you recommending procedures to guard against abuse or behavior modification, seculsion, and restraints differently than what you have already described or are they the same?

A. They are essentially the same, but I am suggesting the desirability of a professional advisor group and of a viable, truly independent human rights advocacy committee so that these two bodies can participate in the review and appeal proceedings.

[1-181] Q. Would you have any recommendations concerning the record-keeping procedures?

A. There are specific requirements and record-keeping relative to behavior-modification procedures. I think they have been well outlined by the Manual on Mental Deficiency, as well as our own guidelines and I would feel confident if these are implemented.

Q. Would you recommend any reorganization in the concept as used at Pennhurst of the units and departments of dual authority?

A. Yes. I feel that the effectiveness and the efficiency of the staff can be significantly enhanced by eliminating the confusion which now exists in terms of team leaders having a dual reporting responsibility.

I also suggest the establishment of a training and demonstration unit for the in-service training of staff.

Q. What would be your policy concerning admissions?

A. I would continue what I assume is currently a moratorium on all admissions.

Q. Would you have any recommendations in this area concerning the population level at Pennhurst?

A. I think that there needs to be deescalated population, drastically, to greatly decrease the density of the population, to integrate the greatest possible number into the community, and to establish a cli-
[1-182] mate in which the basic principles as outlined can be implemented.

I know that there is a proposal to reduce population to around a thousand residents and I feel that is much too large.

Q. Doctor, I presume that for a major deescalation of population there would be a requirement for planning mainly and that it be properly planned and followed.

A. Yes.

Q. Do you have any recommendations in that regard?

A. Very briefly, yes.

Obviously, there is a need for a systematic deescalation plan with long and short-term objectives, including specific numbers, specific time lines, and

a system for program evaluation and review, and this plan must be a systematic plan for vacating specific buildings.

The greatest possible number of individuals must be systematically prepared for community residence. Suitable candidates must be identified on an ongoing basis by the program teams. Residents and their parents or guardians must be involved in this individual planning, including the selection of the most suitable community alternatives.

It is essential that community resources be developed in concert with this overall plan, with adequate budget, advocacy, monitoring, and evaluation
[1-183] of these community alternatives.

As part of this plan I would suggest the establishment of a form of advocacy program.

Q. Doctor, what service is there now provided at Pennhurst that could not be provided in this community?

A. I know of none.

Q. Assuming, Doctor, that services were available in the community, what percentage of Pennhurst residents could be appropriately served in the community?

A. I'd say a hundred percent.

Q. Do you have any recommendations for a monitoring system or an accountability system to oversee such a movement from a major institution to communities?

A. Yes. I would forcefully urge the establishment of a review panel, a panel charged with implementation of the Court's decision, directly responsible to the Court, required to submit periodic commitment reports, possibly every sixty or ninety days, making periodic revision recommendations to the defendants, including specific timetables for implementation.

Such a pattern should have direct access to all information, should be able to visit the institution and to interview.

* * *

[BY THE COURT:]

* * *

[1-185] Did you find anyone among the professional staff during your visits of 1975 and 1977 who, in your opinion, you considered disagreed with any of those recommendations?

A. I don't really think so, your Honor.

I think the major area of disagreement, if there be such an area, is the matter of timing, the time line.

I think there is general agreement on philosophy, on objectives, and on goals.

Q. That question of mine assumed that you must have discussed some of these things —

A. Yes.

Q. — while you were visiting the staff.

A. Quite so.

I think one of the problems we would run across, your Honor, is that there seems to be good agreement on basic philosophy and objectives. The basic problem is one of implementation.

Q. When you say the basic problem is one of implementation, if those that are administering the program at Pennhurst agree with you and your recommendations, tell the Court why they are not being carried out.

A. Part of the problem is the bureaucracy within which the staff has to operate.

Q. When you say the bureaucracy in which they
[1-186] have to operate, are you talking about the bureau-

cracy that is present at Pennhurst or are you talking about the general bureaucracy that is present in all government, including the State government and the Federal government?

Just specifically, what do you mean by that?

A. All right. I am talking about some of both.

Q. I didn't mean to leave out the City over there.

MR. THRASHER: Surely not the Federal government.

THE COURT: All right.

THE WITNESS: I think we are talking about some of both.

I think some reorganization within the institution would help matters and I felt specifically about the problems of classifying individuals, reducing the span of control, and clarifying the lines of administration of some of the key program people. Some of that could be done, I expect within the institution.

Part of the problem, however, is the State bureaucracy, which greatly limits the amount of flexibility which the institutional administrator has in these areas.

* * *

[1-187] Q. Are you saying that part of the problem is the higher level directed down to the institution of Pennhurst?

A. Yes, I think that's true, and the manner in which decisions have been made so that some of the program people may have very little input in some of the key decisions, such as outtakes and that sort of thing.

THE COURT: All right. Thank you.

BY MR. THRASHER:

Q. Dr. Roos, have you completed your major recommendations?

A. Yes, I have. I am not sure I have been totally responsive to the Court in terms of problems of implementation.

I feel I should mention that part of the problem is the need to develop viable community alternatives. The staff at Pennhurst, I think, is keenly concerned about that.

* * *

THE COURT: If I may, I think it is better that I ask these questions now while you still have him on direct examination, if you want to develop something further and also counsel on some later cross examination.

BY THE COURT:

Q. You talk about implementation of these programs in the community.

Do you mean by that that, in effect, Pennhurst should be closed down and that we have separate facilities in small communities to take care of the
[1-188] problems that are now being taken care of at Pennhurst; or do you mean by the words "implementation in the communities" that certain of the now residents would better be taken care of in the community and still have institutions similar to Pennhurst, but along the lines that you are suggesting in your recommendations.

Which is it?

Have I made myself clear?

A. Yes, you have, and you have put your finger on a very key contemporary issue, because I think you will find that there is some division of professional opinion as to which of these alternatives is most desirable.

My own feeling is that as of now I have seen no compelling evidence that institutions can provide

better care than community programs and that, in general, it is most difficult for them to do so.

Now I recognize that to phase out a facility of Pennhurst's size takes time and takes very careful planning so that the residents truly leave there for more desirable settings; but I see no compelling reason at this time why Pennhurst should be retained indefinitely.

Q. Now along those lines, this might be comparable.

I just read or heard recently about the recommendation, I think coming from the Federal Government or some authoritative source, that we could [1-189] cut down, for instance, on the number of hospital beds throughout the country and, as I recall that recommendation, I think there was also included the suggestion that certain hospitals would be devoted solely to certain specializations.

A. Yes.

Q. Now in the interest of efficiency — and it seems to be that that is at least one school of thought — would you suggest, for instance, that there would be, in Pennsylvania, certain locations, not necessary in every community but some central locations, where some special type of treatment or facilities would be available for the retarded citizens?

A. Yes. It is conceivable that there might be small, highly-specialized types of facilities which would have at their focus dealing with small groups of individuals with very specialized needs that it might be difficult to meet in a community setting.

I see that as a possibility.

Q. Then perhaps what your suggestion is that you just don't do away completely with the concept of an institution like Pennhurst, we will say, if it were operated and proceeded along the lines of your recommendation, but in addition to community facilities

then we would still need certain, I will say, centralized treatment facilities and educational facilities.

A. There is certainly one model that has some real [1-190] possibilities. I think when we speak of such a model we are talking about facilities of fifty to a hundred, maybe at the outside, 130 beds; facilities which have a highly-trained and specialized staff, hopefully, which will not be warehouses for the individuals placed therein, but which will be transitory facilities where they will receive intensive treatment and training.

* * *

* * *

[1-193] Q. Let me be a little more precise about what I am after.

Did you form any definite views contrasting a large institution as you and I have discussed previously and as we have been discussing it today vis-a-vis the community-living arrangement?

Do you know when you made the judgment in your own mind that the institution was definitely not superior to or equal to the community-living arrangement as a medium for delivering services to mentally-retarded?

A. I think I reached that conclusion during the time I served as superintendent of the Austin State School, and that would be somewhere around 1965 or 1966, somewhere in that nature.

Q. What were the years that you served in that capacity?

A. Well, as I recall, it was from about '64 to '68.

* * *

[1-196] Q. You indicated that some of the myths that existed unfortunately with respect to mental retardation are still held today by professionals.

Can you elaborate on that?

A. I indicated that, unfortunately, some professionals still hold the myth.

[1-197] Yes, we are from time to time confronted with situations in which a pediatrician, for example, will tell new parents that they have a Down's Syndrome child, a condition easily diagnosed at birth. The parents are told, you know, that this is a hopeless case and you should institutionalize immediately.

Other professionals still hold the premise that mental retardation is really a kind of illness and the patient should be treated in the hospital.

Q. Are these specialists in the field of mental retardation?

A. They are professionals in their respective professions, i.e., Medicine or Psychiatry or what have you, as well as a lot of them in the field of mental retardation.

Q. Is there unanimity in the field of mental retardation with respect to the proposals that you have set forth today and the general ideas that you have set forth today with respect to institutions vis-a-vis community-living arrangements?

A. I would be most hesitant to attribute unanimity to any group of individuals, and that applies also to professionals in the field of mental retardation. There is quite a scope.

However, the Delphi study which I mentioned which did bring together a panel of recognized experts, did lead to unanimity on a number of the key points that I raised today, such as the tendency of large institutions to be phased out, the great growth of community-based programs, and the desirability of such community-based programs.

[1-198]

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Testimony of J. D. Clements — direct

* * *

[2-12] BY MR. PEABODY:

Q. Dr. Clements, how are mentally-retarded persons different from normal persons?

A. I would like to turn that around a little bit and say that I think that mentally-retarded people are more like normal people than they are unlike normal people. For example, mentally-retarded people

[2-13] have the same ability to love, to hate, to feel joy, pain, sorrow, as you and I.

The most striking difference, I guess, that we would note when we observe retarded people is the development of some of their abilities to do things is at a slower rate than what we would normally expect.

Q. In what basic areas do normal persons develop?

A. If I can be general, we generally think about development as physical development, social development, intellectual development, and emotional development. Those are the broad categories.

Q. Does everyone develop in these general categories?

A. Yes, everyone, including retarded people, have developmental spheres in these catetories and certain capacities within these categories to develop.

Q. Is everyone born with the same capacity?

A. No.

Q. Is it then that individuals develop in these areas in different ways and at different rates?

A. Yes, they do.

Q. Is it determined at birth what an individual's capacity will be these areas?

A. No, it cannot be determined at birth.

* * *

BY MR. PEABODY:

Q. Now, Dr. Clements, you have stated it cannot be determined at birth what an individual's capaity will be.

Is there a certain age where these capacities
[2-16] can be determined in the areas that you have outlined?

A. Well, the determination sometimes, as we discussed earlier, is very difficult. I et me say that generally an individual is born with a certain capacity in various areas. It depends on what happens or does not happen to that individual whether or not that individual will develop up to that capacity or ceiling or whatever you wish to call it.

In the area of emotional development, ordinarily our capacity is fixed around the age of five or six years, so you either gain all that you are going to be able to get ultimately capacity-wise by that time.

With intellectual development we would say ordinarily by the time a person is 16 to 21 years, the intellectual capacity is fixed.

With physical development, generally, early adulthood in some areas, for example, the cardiac muscle, the heart muscle, we will say up to age 25. That's when the capacity would be determined.

As far as social development, which is probably the most important item here in the way an individual is able to live his life — in social development we continue to develop in those areas throughout life if given the proper opportunity.

Q. Those areas that you have outlined that have ceilings, as you put it, at certain age levels, I take it then that after those periods are reached one can
[2-17] only work within the capacity that one has reached at that age level.

A. That's correct.

I should be very clear on this. It is the capacity that becomes fixed. By saying the intellectual capacity has been reached does not mean that I can't continue to learn, but I can't learn at a higher or more efficient rate than what has already been developed.

* * *

[2-18] Q. Dr. Clements, have you had an opportunity to visit and evaluate the Pennhurst State School and Hospital?

[2-19] A. Yes, I have.

Q. When did you visit?

A. My visits were on March 24, 25, 26 and 27, 1975.

Q. Is that your only or most recent visit to Pennhurst?

A. Yes, it is.

Q. Could you describe generally for us what you did while you toured?

A. Yes.

On the first day we visited with the superintendent and other officials of the school, got information from them about the operation of the facility, the type of population that was there.

We asked the superintendent to give us examples of areas that he would suggest that we see, that he felt, for example, were the best that they had, an average situation, and the worst that they had.

The first day was spent really visiting all of the residential areas and certain of the program areas.

Q. Every residential unit?

A. Yes.

The second day, I think we finished with a couple of units that we had not visited the day before; and then did a more detailed visit to certain areas that were selected, including those areas given to us

by the superintendent. We continued that rather detailed examination of the units on the third day.

[2-20] The afternoon and evening of the third day were spent revisiting many of the areas, including photography of those areas.

The fourth day I spent examining records and than I had a summation conference with Dr. Youngberg and certain staff that he had selected.

Q. And during your evaluation you talked to the various professionals running various programs at particular departments, physicians, and the like?

A. Yes.

Q. Are these, in your view, people who are responsible for implementing the carrying out of practices and policies at Pennhurst?

A. Yes, they are.

Q. Now you mentioned that upon conclusion of your tour you had an interview with the superintendent and other professionals?

A. Yes.

Q. And what was the purpose of this interview?

A. The purpose of the interview was to discuss with them what I had interpreted that I had seen in case they felt that I had made any errors of understanding about what I had seen. It was an opportunity really to tell me additional things that I may not have found, and also to give them my impression of what I had seen at Pennhurst.

* * *

[2-28] Q. Dr. Clements, did you form an opinion as to whether the professional staff at Pennhurst during the time of your tour was adequate to provide minimally-adequate care and habilitative treatment to Pennhurst residents?

A. In my opinion, it was not.

Q. Are certain levels of direct-care staff also necessary to run any kind of minimally-adequate habilitative care and treatment program?

A. Yes. There are several standards, Your Honor, used for calculating direct-care staff.

The Wyatt order called for an overall ratio of one to one. That is, if you had 1265 residents you would need 1265 direct-care staff. They also break that down using mild, moderate, and severe, how you would use that.

The Joint Commission on Accreditation of Hospitals also recommends an overall ratio of one to one for most of the types of residents that you see at Pennhurst.

The regulations governing intermediate-care facilities for the mentally-retarded, which are the so-called nursing homes for mentally-retarded people, recommend as a minimum one to two.

[2-29]

Q. And are these —

BY THE COURT:

Q. Are nurses in the direct-care category?

A. No, sir, they are not.

BY MR. PEABODY:

Q. And are the standards that you have outlined also generally accepted by the professional persons in the field?

A. Yes, they are.

Q. Now is it particularly important for the direct-care staff to be appropriately qualified?

A. Yes, it is.

Q. Could you describe the kinds of qualifications needed to carry on the kinds of activities that they are there to carry out?

A. Well, I think an individual certainly needs to be, at a minimum, able to read, write well, and understand what is written.

He also has to provide for people additional training once they come to the facility to work and then again this is the type of thing that would certainly depend on the area in which they were going to work.

For instance, if they were working in an area where people were simply not ambulatory, you have to teach feeding techniques, you have to teach
[2-30] lifting techniques because these people can not get about and go to different places unless they are actually lifted out of bed to do so.

There are a multiple of things that have to be taught. On the other hand, you have to have a basic amount of education to benefit from that type of teaching.

Q. Did you form an opinion as the result of your tour on the qualifications of the direct-care staff at Pennhurst?

A. Well, I can only repeat what I told, that the average educational level of the direct-care worker at Pennhurst was the fourth-grade level and that, indeed, some could not read nor write.

Q. Did you ascertain the number of direct-care staff in census at Pennhurst on the date of your tour?

A. Yes, sir, I did.

Q. And did you form an opinion as to the adequacy of the direct-care staff at Pennhurst?

A. Well, if you take the total number of direct-care staff that were at Pennhurst, they fell between that one-to-one and one-to-two figure, so, numberwise, they would not quite meet what the Joint Commission recommends.

On the other hand, it was substantially above what the regulations for intermediate-care facilities for the mentally-retarded require.

However, they also require certain shift ratios. For example, the important thing is not how many

[2-31] people you have employed, but how many are at work, your actual number of units doing the job, so there are ratios spelled out for this.

For example, with the severely- and profoundly-retarded the Joint Commission recommended that there be on duty at least one employee to every four retarded people, that is, on the first two shifts; and at night they recommend that there be at least one employee for each eight individuals during the hours that they are ordinarily sleeping.

Q. Are there other factors at Pennhurst which draw the number of direct-care staff assigned to the particular ward away from the ward so that they are not on the ward to deal with the various residents?

A. Well, that's true not only for Pennhurst but any other facility. There are people that have to go on errands, there are people who have to arrange transportation.

As I mentioned earlier, you have got to provide time for these people not only to get original in-training service, but to keep updated on the training that they have; and that activity frequently would take them away from the ward area.

Q. Was that a particular problem at Pennhurst?

A. Well, yes. It's a problem at Pennhurst as it is at any other place when you have to pull short staff away from a living unit.

I did a survey of quite a number of the build-

[2-32] ings during the days that I was at Pennhurst, basically three days.

Q. Which units did you pick out for more intensive study?

A. I have C-10, K-1, C-9, D-1, C-7, C-8, and 52; and I did staffing ratios for March 22nd, 24th, and 26th, all shifts.

These were the people that were actually there in those theaters.

Q. Could you describe for us how you picked out these particular units to study more carefully?
A. Well, the units that I picked out included the three units that Dr. Youngberg had originally suggested that I look at and I picked out four additional units essentially at random.
Q. And for these units do you have figures as to the levels of retardation and could you compute the various ratios?
A. Yes, I did.
Q. Could you give us some examples, please?
A. C-10, for example, is a unit described for the severely-retarded and it is one of the units certified or was at that time as an intermediate-care facility for mentally-retarded.

On the 7-to-3:30 shift or the first shift on March 22, '75, the ratio was one to 30; on the 3-to-11, or second shift, the ratio was one to 61; on the third shift, the ratio was one to 20.

The ratios were similar the next day, the next two days.

For example, K-1, on March 26, 1975, the first
[2-33] shift, one to 24; the second shift, one to 16; the third shift, one to 24.

And C-8, which is said to be for profoundly retarded people with different behaviors, it is also certified for an ICF/MR unit, there are 36 people living on that unit. On March 22, on the first shift, there was a ratio of one to 12; on the second shift, one to 12; on the third shift, one to 18.

And on the 24th of March and the 26th of March the ratios were the same.

THE COURT: All right.

[2-36] BY MR. PEABODY:
Q. Now, Dr. Clements, in your opinion, does Pennhurst present an habilitative environment

where retarded individuals may grow and develop and reach their full potential?

A. No, it does not.

Q. Would you describe generally how it is deficient?

A. If I can speak generally, let's say that the living situation at Pennhurst is one of large day rooms, large sleeping areas, where large numbers of people congregate and live together.

In most cases there is no pretense of privacy, the noise level is extraordinarily high, the level of supervision of residents is low.

Programming at the time of my visit was almost non-existent.

You have a situation at Pennhurst in which individuals come into that facility and live in those conditions. If the individuals were talking, were able to speak, at the time of admission, with the noise level, the chaotic situations there, some of these individuals are likely to stop speaking because in that situation one can not use the language one has acquired.

If an individual is toilet-trained and the bathroom facilities are either not available or sufficient,
[2-37] one can no longer use those skills that one has learned in toilet training.

What I am saying is that the environment at Pennhurst is not conducive to acquiring new skills; indeed, it is more conducive to losing skills that one has already developed.

* * *

BY MR. PEABODY:

Q. Dr. Clements, I would ask you to look at Photo No. 1 on Page 1, if you will, and ask you if it is an accurate representation of what you saw on March 26, 1975, the day room in Residence C-9.

MR. GOLDBERG: Excuse me, Your Honor.

Is that Exhibit 48 again?

MR. PEABODY: Yes, Exhibit 48.

THE WITNESS: Yes. I was there at the time the photograph was made and certain things I think are noteworthy when one is looking at this photograph.

First of all, there are two individuals being bathed or assisted in bathing in the same tub. There is no provision for privacy despite the fact that there are three other residents in the room in various stages of bathing.

The bathing in the tub is being carried out by hose arrangement.

[2-38] It is a dangerous situation to have two residents in the tub together. You might look over at the other side of the photograph and you see a nude resident sitting in a wheelchair, also being bathed. The individual is what I would call a spastic person. Her leg is being pulled up into the air, putting her in a precarious position in that chair, from which she could easily slide out and injure herself.

There are a total of one, two, three, four, five residents and two employees in this bathing situation. I consider that a degrading, dangerous, and dehumanizing scene.

BY MR. PEABODY:

Q. Could you say what spasticity is, please?

A. Yes. Spasticity is a condition that's due to a central-nervous-system, that is, brain injury, in which the individual has difficulty extending, generally, the extremities fully. That is, it becomes very difficult. The muscles are, in essence, tight.

Q. Stiff?

A. Stiff.

Q. Is the bathing of two residents in one bathtub hazardous?

A. I would say so. If one resident slips he is very likely to take the other resident down with him. One resident can grab the other resident and injure him in that situation.

The employee, as you may note in that picture, is also leaning over at a rather precarious angle to be
[2-39] assisting the two people in the tub.

Q. Dr. Clements, I now refer you to Photograph No. 5 and ask you if it is an accurate representation of the toilet or bathroom area which you observed on Day 1.

A. Yes, it is. I was there at the time the photograph was made.

MR. WATKINS: Your Honor, K Building has since gone down.

I don't know if you want to spend time on these photographs. They are entirely irrelevent.

MR. PEABODY: Your Honor, I think we should briefly because there were residents living there at the time of the tour and they illustrate many of the relevant points which would be pertinent.

MR. WATKINS: I think we are only concered with respect to the United States and it makes no sense to me since that building no longer exists.

MR. GILHOOL: Your Honor, if I may, the superintendent of Pennhurst, on depositions, testified that 500 people at Pennhurst as of the date of the deposition, approximately six weeks ago, lived in buildings which he had recommended be torn down three years ago. They have not been torn down.

I think, therefore, pictures of K-1, which happily has been torn down, are nonetheless appropriate and admissible and relevant for looking at because
[2-40] there are evidently a good many other places similarly inhabited.

THE COURT: I will note your objection.

As to whether it is relevant the Court will take into consideration in making its finding your objection.

We will proceed.

THE WITNESS: The photograph that I am looking at shows a bathroom area. There are five toilets with no provisions for privacy, no toilet seats, in a large open room, in which the floor covering obviously is almost worn away, creating a problem of slipping, stumbling, and tripping.

Again it shows a complete lack of a sense of need for privacy of people.

BY MR. PEABODY:

Q. Dr. Clements, I now refer you to Photograph No. 6 and ask if you will —

MR. WATKINS: My same objection is noted for all the photographs that deal with Building K.

THE COURT: Yes, it will be noted for Building K, as long as somebody points out that this is Building K that they are talking about.

MR. WATKINS: Could I ask counsel for the United States to do that?

MR. PEABODY: I will mention Building K.

THE COURT: Yes.

THE WITNESS: This photograph is made in
[2-41] the same bathroom area previously described.

Again, you note the worn, hazardous floor covering; a break in the cover of the radiator with sharp metal prongs sticking out creating an immediate hazard.

Additionally, you may note in the photograph that the line leading to the radiator, the hot-water or steam, is not completely covered. The insulation has either fallen away or broken away, which is a hazard for people getting burned.

BY MR. PEABODY:

Q. Dr. Clements, I now refer you to Photo 7 and ask you if that's an accurate representation of Bathroom C in K-1.

A. Yes, it is.

Again, you note that there are three sinks. You do not see any soap or towels in this photograph.

I can also say that at the time of my visit there were not towels nor soap available for hand-washing at the time I was there.

Again, the same hazardous floor condition, you will notice.

Q. Does the absence of soap and towels have any consequences for treatment?

A. Yes, it does. Infection, the transmission of infections or communicable diseases is always a problem in congregate settings. It is more difficult to completely cleanse the hands without adequate soap and towels.

[2-42] Q. Does it also discourage residents from learning how to wash their hands?

A. When individuals are being taught by various techniques to do certain things, you do it step by step, in ways one would ordinarily expect them to be performed in a place where you ordinarily expect to do this.

Part of the steps of adequate washing are the use of soap and the adequate drying with towels following this procedure. If your hands are still wet following that procedure, again, then there is an immediate infection-transmission hazard.

So if individuals are taught in a situation in which there is no soap and no towels an individual does not learn the procedure properly to begin with. Obviously, if the individual did not learn the procedure properly, even if soap and towels were available in another setting, the individual is not likely to use them.

Q. Now, the deficiencies that you described in K Building on the date of your visit, were they occurring in other buidings?
A. Yes, they were.
Q. Not just K Building?
A. Not just K Building. This was a general deficiency throughout the facility, that is, lack of soap, lack of towels, lack of toilet seats.
Q. I now refer you to Photograph 39 on Page 20.
A. Yes.
[2-43] Q. And I ask you if that's an accurate representation of showering which occurred on Ward C-13.
A. Yes, it is. In essence, it shows one person who is an employee standing and observing two nude males in showers.

Again, there is no provision for privacy. The ICFMR regulations specifically state that there must be provisions for individual privacy in toilets, showers, and other bathroom facilities. It is a flagrant violation of the standards and the regulations.
Q. I now refer you to Photograph 42 on the next page and ask you if it is an accurate representation of a scene that you saw on Ward C-8.
A. Yes it is.

Again, there was congregate bathing in the bathroom. There were so many people in the bathroom that there was no adequate space, for example, for individuals to adequately dry themselves and change in the bathroom, so the procedure, as I recall it, was simply this — you went in and were showered and came out into this area for toweling and drying.

You may note that there are sheets or some other cloth material on the floor. The reason for that is that these buildings are generally built of hard-surface materials and when this flooring, for example tile or terrazzo, gets wet it is extremely slippery

and hazardous, so sheets were being put on the floors to try to cut down on that hazard of water on
[2-44] that hard-surfaced floor.

Q. I would next refer you to Photographs 43 and 44 on the next page and ask you if that's an accurate representation of showering on Ward C-8.

A. Yes, it is. It shows several nude females, again standing together, toweling themselves and being assisted in toweling, again with no provision for privacy made; the same type provision of sheeting material on the floor to try to cut down on the slipperiness or the hazard of slipping on the floor.

Q. You have used the term "congregate bathing."

A. Yes.

Q. Would you describe what you mean by that?

A. What I mean by this is that there are a number of individuals in the immediate area using the same facilities at the same time.

Again, the obvious objection that I would have, No. 1, is the lack of provision for privacy, plus in a chaotic situation of this type the possibilities of injury or accident are much greater.

Again, it is very difficult, for example, in this type of setting, where it is noisy, it is rushed, where there are a number of people there all together — it is very difficult to teach an individual to adequately bathe himself and one of the things that you are after or one of the first things to try to do is to try to teach individuals to help themselves.

If it is easier in this situation to do it for the individuals then let them do it themselves, therefore, there is a great tendency, Your Honor, to actually
[2-45] lose skills that you already have.

Q. Dr. Clements, during your tour did you have occassion to see residents being bathed but no soap being used?

A. Yes, I did.

Q. And could you tell us about that?

A. Well, yes. Again, it is extremely difficult to adequately clean a person without soap.

I saw situations, for example, in which a common bathcloth was used, in which there would be soap placed on that bathcloth and several residents soaped with this particular cloth.

Again, there is an infection hazard.

BY THE COURT:

Q. So you did see some soap there?

A. Yes. In other areas there was not soap.

BY MR. PEABODY:

Q. Were these congregate bathing practices you have described carried on in other buildings also during your tour?

A. Yes. That was the general situation rather than the exception.

Q. I now refer you back to Photograph 2 on Page 1 and ask you if that is an accurate representation of a
[2-46] bedroom scene on Building K-2.

A. I am sorry, which photograph?

Q. No. 2, Page 1.

A. Yes, it is.

Q. I am sorry, Photograph 2 is a non-ambulatory bedroom on Ward C-9.

A. What the photograph shows is a large number of what I would guess most of us would call crib-type beds, that is, they are beds with side rails to prevent individuals from rolling out of the bed.

There are a large number of these beds in a large open space. In fact, the beds are so close together it is difficult to get in between.

It would certainly be difficult to move individuals out in this situation. The problem again, as you will note in the photograph, is that with all of these beds and people lying in beds, there is an individual

in bed nude. I assume they were in the process of changing a diaper or changing clothes, again, with no consideration or provision for privacy.

Q. Is this resident also spastic?

A. I beg pardon?

Q. The resident that you described, is that resident also spastic?

A. The patient appears to be from the photograph. He has quite a contorted position.

* * *

[2-47] BY THE COURT:

Q. I noted that in commenting on several of the photographs you pointed out that the individual in the photograph was spastic.

A. Yes, sir.

Q. What is the relationship between that condition and retardation generally?

A. It is an associated relationship, Your Honor, in people who have cerebral palsy and who are spastic. About one third of those individuals are retarded.

It is a condition that frequently is also found — it is a symptom that is also frequently found with the symptoms of mental retardation. They frequently occur together.

Q. Is there any explanation that the medical profession has as to why that should occur together on so many occasions?

A. Well, there are certain conditions in which you would find both the spasticity and the mental retardation.

* * *

[2-50] BY MR. PEABODY:

Q. Doctor, are spastic conditions and other like-related conditions due to poor or inappropriate physical therapy?

A. Yes. The spastic condition *per se* would not be due to poor, inadequate physical-therapy techniques. The situation that you would get into is that the situation would become more severe because of lack of proper intervention techniques.

For example, an individual is usually, say, around six or eight months of age before this spasticity is recognized. At the time it is recognized the muscles are not as stiff. Generally, one can still extend the arms fully, the legs fully, go through the full range of motion that you and I could go through.

Unless some rather sophisticated techniques are used, including physical-therapy techniques, and are used with great intensity the individual will develop what we call contractions, that is, the arm may be flexed back in this position, bent, pulled backward; and when an individual develops a contraction the arm can no longer even forcefully be straightened by another individual.

[2-51] So what you attempt to do with the physical therapy is to keep the arm moving so that these contractions do not develop because once the contracture develops the only way that you would really straighten this arm is by surgery.

Q. I take it then that early intervention is important for remedial actions for this condition?

A. It is, vitally important.

Q. Now referring you to Photo No. 19 on Page 10, I now refer you and ask you if it is an accurate representation of a bedroom area on Ward Q-2.

A. Yes, it is. Again, the photograph shows large numbers of individuals sleeping in beds quite close together.

I am having a little difficulty seeing these photographs from the glare, but the photograph, I believe, represents an individual lying in bed, restrained on the lower left-hand side of the photograph.

Q. By the ankles?

A. Restrained by the ankles, and I am not sure, there may well also be an arm restraint but I can't see that photograph very well.

* * *

[2-54] BY MR. PEABODY:

Q. Dr. Clements, I now refer you to Photographs Nos. 29 and 30 on Page 15 and ask you if they are accurate representations of bedroom areas on Ward 47.

A. Yes, they are. Again, what the photographs depict is a large open area with hard-surfaced floors, hard-surfaced walls, high ceilings, in which there is some attempt made at visual privacy for the residents. There are low dividers separating the area into areas of one to two beds in each of these divided areas.

Again, this divides only for minimal visual privacy, particularly while lying in bed, but again provides no auditory privacy.

The situation that one runs into, particularly at night, in an area like this is if one individual is having difficulty sleeping or is crying, coughing, what have you, it is disturbing to the rest of the individuals in this area.

Q. Is there a problem in these areas also in terms of lack of appropriate stimulation?

A. Yes. Again, as I said, the walls again are hard-surfaced, the floors are hard-surfaced.

It is rather barren. There's minimal furnishings, no decorations.

In my opinion, it is very unstimulating environment except from a negative sense. The high noise
[2-55] level would be stimulating in that condition.

Q. Now are the problems that you described in the bedroom areas that you have described typical and representative of other such areas in the institution generally?

A. Yes. Most of the sleeping areas in the institution are not unlike this.

Q. Dr. Clements, I now refer you back to Photograph No. 12 and ask you if it is an accurate representation of the non-ambulatory female day room on Ward C-9 on the date of your visit.

* * *

A. Yes, it is, and the photograph shows a number of individuals sitting around unattended, inactive, no program is going on.

The thing that I think is most obvious in this photograph is if you take a look at the wheelchairs and the other equipment that's being used in this area, this equipment is not adapted, sizewize or otherwise, to the particular needs of the individuals using the equipment. The problem with this is this:

Individuals who are spastic tend to assume the most comfortable position, as you or I would, and what happens inevitably is that this position over long periods of time tends to become fixed.

Therefore, if you take an individual, for example, at one point who really was able to sit upright,
[2-56] because of their condition and the lack of adaptive conditions is allowed to slide down or sidewise into her wheelchair, eventually this individual can no longer assume any other position.

The only way that I know to prevent that individual of this type is to fit that chair to that individual's needs and utilize the chair and the proper fit-

tings in order to support the individual in an upright position.

Now the upright position is vitally important because, as you will note from the photographs, the striking thing here is that both sides are looking down, and if an individual spends their waking hours looking down their world is very small. Their world is the floor or their lower extremities.

An individual does not learn while in this position, so it is an actual hazard to the individual in the sense that it narrows the scope of their world and narrows the amount of intellectual stimulation that an individual receives and physically it is a great danger if the individual becomes fixed in that position and the only way the individual will ever again get out of that position is by rather drastic surgical procedures; and there is no guarantee that those surgical procedures would be effective.

Q. Can you describe briefly how appropriate physical-therapy procedures adapt the chairs so that they become individualized?

A. Again, the individual would have to be actually measured and the chair would have to be padded or
[2-57] stuffed or built to fit the contour of the individual's body in order for there to be any support for that person.

The individuals here can not sit and maintain an upright position as you and I can. They need the assistance of special equipment to allow them to do so and the startling thing about this photograph is that this is standard equipment that you buy in certain standard sizes.

That equipment is supposed to be further adapted to that individual's needs before it is used by that individual; and in this case, as you see, it is not.

Q. I now refer you to Photograph No. 21 on Page 11 and ask you if it is an accurate representation of the day room on Ward 48.

A. Yes, it is; and again the thing that you see so striking in this photograph is a large room, obviously hard-surfaced floors, walls, ceilings.

The light is shining, glaring off of those surfaces.

A large number of people sitting around the perimeter of this room doing nothing. It is quite obvious that this is not the middle of the night. It is obviously in the daytime with the light shining in those windows.

It is again a barren environment. There is an obvious lack of planning. The individuals are simply sitting there whiling away their lives.

Q. I now refer you to Photograph No. 26 on Page 13
[2-58] and ask you if it is an accurate representation of the day room you viewed on Ward 47.

A. Yes, it is, and the scene is essentially the one which I described in the photograph before — again, the large day room and a number of individuals sitting around, in which organized activity obviously is not going on except between one employee and one resident.

Q. I now refer you to Photograph 32 on Page 16 and ask you if it is an accurate representation of a corridor on Ward 48.

A. Yes, it is. Again, it shows a wide expanse of corridor, a long corridor, again with hard-surfaced materials both on the floor and the wall. It is tunnel-like in appearance.

Again, as I recall, when I was there the noise level was quite high. It is just another representation of a very drab, barren environment, which is not uncommon at Pennhurst.

Q. Are the drab and non-stimulating environments you described typical of most like areas at Pennhurst?

A. Yes, they are.

Q. Now what consequences does that environment that you described and the lack of staff that you described and some of the professional practices you have described have on the residents at Pennhurst? What is the impact?

A. The impact on the residents at Pennhurst is essentially a situation in which one is more likely to regress than to progress.

[2-59] As I stated earlier, individuals who come into this type of environment frequently lose the ability to speak. Individuals who come into crowded, chaotic environments, who were walking, tend to lose the ability to walk.

Individuals who come into this environment and they don't have proper programs, proper equipment, such as the adapted wheelchairs I was talking about earlier — these individuals who are able to sit upright tend to lose the ability to sit upright.

In other words, individuals don't gain skills. The more likely situation is that they will lose skills.

Q. And your professional opinion is that the environment at Pennhurst fosters this regression and loss of skills?

A. It does.

Q. In your opinion, does the environment also foster the occurrence of physical injuries?

A. Yes, of course, it does.

When you have individuals, for example, who have some difficulty anyway in getting about because they have physical defects of many kinds, seizure disorders, whathaveyou, when you have hard-surfaced floors, for example, they become extremely slick when wet, and it was not uncommon at

Pennhurst, for example, to see wet floors from showering, floors wet with urine and other materials.

[2-60] There were maintenance problems at Pennhurst. I think if you look at the radiator cover that was broken, things of that type, that increased the likelihood of accident and injury.

When you have large numbers of people congregated together, particularly milling about in a chaotic fashion, one individual tends to injure another individual.

There are numerous scenes at Pennhurst that I saw of individuals that were suffering from repeated old injuries, injuries that had occurred repeatedly.

I remember one scene, for example, late in the evening on one day that I was at Pennhurst. We were going about and there was one direct-care person sitting on the ward and there were a fairly large number of adolescent males in this unit that were quite active, and when we entered the room one young man was severely beating another young man.

The employee was sitting there watching. When the superintendent who was with me at the time questioned the employee as to why are you allowing a situation to occur? Why don't you intercede?

The employee's remark was that's not in my job description.

Q. Doctor, I now refer you to photograph numbered 25 on Page 13 and ask you if this is an accurate representation of the resident you saw in Room K-25.

[2-61] A. Yes, it is.

I think I spoke just a few minutes ago about the fact that there were so many residents that had remarkable scars representing repeated old injuries.

Q. Is this an example of that?

A. This is an example. It is a young man sitting on the floor, as you will notice, his scalp — his scalp is just criss-crossed with scar tissue.

Q. Did you see numerous other residents with other such evidence of prior injuries —

A. Yes.

Q. — in your visit?

A. Yes, I did.

You know, it is a little more dangerous than it looks on the surface of this because with repeated injuries to the skull, the head, what one can eventually end up with is a situation which we sometimes see in prizefighters, when they say they are punch-drunk.

You get repeated contusions to the brain and you decrease your intellectual capacity when that happens.

Q. Dr. Clements, did you note any other deficiencies which placed residents in imminent danger of possible threat of physical harm or death?

A. Well, yes. I mentioned, you know, that when you have large groups of people together you immediately increase the hazard, regardless of your traffic.

[2-62]

When you have inadequate traffic, of course, you just compound the error.

Q. Did you observe any improper feeding techniques during your tour?

A. Yes. There were a number of errors at Pennhurst, in which the individuals there are essentially confined to bed unless they are taken out.

I observed on several occasions feeding going on in those areas; and in certain cases, individuals who were being fed were lying flat.

If you have ever tried to drink water when you are lying flat in bed you can understand the difficulties of doing this.

In addition to that, most of these individuals are again cerebral-palsied or spastic as we were talking about earlier; and because of that you have even more difficulty than you and I would in swallowing food or liquid.

So you create an immediately-hazardous situation, hazardous to life by feeding an individual, No. 1, without knowing and utilizing the proper feeding techniques; and, secondly, by feeding them flat. It was not unusual at all to see individuals lying flat while being fed with the expected result of coughing and choking during the process.

Q. Can you describe generally what the proper
[2-64] feeding techniques are for such persons?

A. Well, for a person who is spastic, or any other person, they need to be as upright as possible while feeding, while they are either feeding themselves or while someone is assisting or completely feeding them.

You need to know if the individual has difficulty swallowing and if there are certain techniques that you can use to assist that individual.

For example, you can stimulate the individual's lower lip to help him in the swallowing process. There are many techniques that can be used.

It is hazardous at best when you are feeding another person, particularly a person who is spastic and has difficulty.

Special feeding utensils are required at times. I recall very well seeing an individual — while I am not sure at Pennhurst, when I recall on my tour at Pennhurst, being fed applesauce.

This individual was absolutely flat in bed and this individual finally coughed and spewed out the entire amount of applesauce that they had been fed.

The applesauce had gone to the lungs rather than the stomach. This creates an immediately-haz-

ardous situation to life, not only from choking and immediate aspiration, but the fact that it increases the chance of acute and chronic pneumonia and ap-
[2-65] parently damage to the lungs.

Q. Are there also hazards for persons who are in inappropriately-fitted wheelchairs, so that, therefore, they don't have good position when feeding is done?
A. Yes. The same hazard would exist as I have just described.
Q. And did you see a number of the kinds of inappropriately-fitted wheelchairs that you described a few minutes ago, throughout the institution?
A. Yes. This was generally the situation. It was not the exception.

There was very little adaptive equipment used at Pennhurst on the time of my visit. Of course, most units did not have enough wheelchairs for the cerebral-palsied or spastic patients.

In many instances Therapy used many times what is generally referred to as cripple-carts. They are wooden carts with what appear to be bicycle wheels and these are used to roll people about in the flat position.
Q. I refer you to Photograph No. 11 on Page 6 and ask you if that is an accurate representation of the kind of cart that you have just described, this wooden cart being on Ward C.
A. Yes, it is. It shows an individual lying in that cart, which I have referred to as a cripple-cart, covered, essentially, by what appears to be a sheet or a blanket.

Just the top of the individual's head is visible.
[2-66] The individual is obviously in a very awkward position lying there.
Q. And is this the kind of person who could have had the feeding problems that you have described?
A. It is; not only that, but individuals with severe

spasticity and cerebral palsy tend to have difficulty even handling their own secretion, that is, swallowing their own saliva; and they tend to choke on that as well.

It would be very difficult for a person in the position in which you see this individual lying. It would increase the hazard of aspirating their own secretions.

It would be really difficult for even the individuals to really cough up their secretions in that position.

Q. With proper feeding and proper training can the hazard you have described be reduced?

A. The hazards can not be eliminated. They can certainly be substantially remedied.

Q. Now you have mentioned that one of the results of improper feeding can be aspiration, aspiration pneumonia, I believe you mentioned?

A. Yes.

Q. Can you describe what these terms refer to?

A. Well, for example, if one is attempting to eat and swallow and rather than the food going down into his stomach it goes down into the lung, food acts as
[2-67] a foreign body with tissue. It sets up an inflammatory reaction within the lungs, which then also tends to become infected and you get a pneumonia, just as you would from getting it with any other bacterial agent.

Individuals of this type tend to repeatedly aspirate at least some amount of materials and get a chronic pneumonia and chronic lung damage and that's the problem with which you are dealing.

Q. Is asphyxiation also possible.

A. Oh yes. Individuals do choke and because of their inability to get air in and out die. This is always a hazard with a person who has difficulty handling secretions and food. You increase that hazard by

utilizing improper feeding techniques and improper position.

* * *

Q. Dr. Clements, I now hand you government exhibit marked No. 13, death records, Pennhurst State School and Hospital, January, 1974, to January of 1977 and ask you if you have reviewed that.
A. Yes, I have.
Q. And what are these records?
A. These are records, some post-mortems and some not, of the diagnosis of the individual who has expired — the cause of death.
[2-68] Q. Do they include autopsy reports?
A. Some do, yes.
Q. And do others include clinical notes, progress notes, where the events leading to the death are described?
A. They do.
Q. And could you tell us why these records are customarily kept in institutions, including Pennhurst?
A. Well, records are kept in this fashion to give one an appraisal of what is happening in the situation.

For instance, at a general hospital you would also keep records of this type and it is for an assessment of the effectiveness of your program.

For example, if we found in an area that there were deaths, a substantial number of deaths due to injury, this would give me some cause, for example, as to what might be going on in that particular area and what might be done about it to correct the situation.

The records are an assistance to let you know what is going on and to assist you in improving and providing the best quality care for them.
Q. So that the records reporting occurrences from

certain deaths, certain deaths might be prevented in the future?

A. One would certainly hope that it would be of assistance in that regard, yes.

MR. PEABODY: The United States would
[2-69] move into evidence Government Exhibit No. 13.

THE COURT: It will be received in evidence.

(Plaintiffs' Exhibit P-13 received in evidence.)

BY MR. PEABODY:

Q. What do these records indicate, Doctor, by way of death by aspiration, aspiration pneumonia, and asphyxias?

A. There were a substantial number in these records. As I recall it, at least 10 deaths allegedly due to that cause.

Q. Do you have any opinion —

BY THE COURT:

Q. 10 deaths within the period —

A. Of less than two years.

Q. Less that three years?

A. Two years, I believe.

MR. PEABODY: 1974 through the first month of 1977.

THE COURT: All of 1974, all of '75, all of '76, and the first month of 1977?

MR. PEABODY: Three years; that's correct.

* * *

[2-70] BY MR. PEABODY:

Q. Doctor, do you have any opinion or impression as to why there are such deaths by aspiration and aspiration pneumonia and asphyxiation?

A. No. As I said, the situation at Pennhurst certainly makes it likely that this type of thing is going to occur.

I would have to go back and examine each case to know if what was, in fact, the cause or this were the situation that happened.

I would not form any impression from these records of the deaths related to the deaths at Pennhurst. I simply wouldn't be able to.

Q. But you have concluded upon your review that there were deaths by aspiration, aspiration pneumonia, and asphyxiation?

A. That is correct.

Q. And within your experience, sometimes not necessarily in these exact cases, poor feeding practices lead to such deaths?

A. Poor feeding practices can lead to such situations.

Q. And within your experience, can proper feeding techniques perhaps reduce the incidence of such deaths by aspiration, aspiration pneumonia, and asphyxiation?

[2-71] A. Yes, without question they can.

Q. During your tour, Dr. Clements, did you observe any other feeding techniques or feeding practices which were, in your opinion, inappropriate?

A. Yes. On several occasions which we observed in feeding there was an unusual amount of time, for example, between the time that the food was placed on the table and the resident was able to utilize the food.

At one situation that I can only describe as very gross, one evening, as I recall, the time between the time that the food was placed on the table and the residents began to eat their food varied roughly from 14 minutes to 45 minutes. The food was cold at the time.

Another problem is that there were large numbers of people eating in that room and you really couldn't provide any assistance to the residents who

were eating, some simply gulping the food and some, in some cases, using spoons and some hand-feeding.

In certain patients, one resident would steal food from another resident so that he got more and the other person got little or none.

A great deal of the food went onto the floor.

Again, one of the problems in this situation is the very rapid way that an individual eats. It is hazardous because he is simply cramming it down very quickly.

[2-72] One reason that this occurs is that with people sitting so close together, if they don't eat quickly their food is stolen.

It certainly, in no fashion, in my opinion, allows the residents to eat in a normal fashion or to enjoy meals that are served. It is a situation more of survival than pleasure.

Q. Dr. Clements, I now refer you to Photograph No. 34 on Page 17 and ask you if that is an accurate representation of the dining area in the basement of Building 2 and an example of the practice that you have just described.

A. Yes, it is.

Q. I would next refer you to Photographs 36 and 37 at Pages 18 and 19 and ask you if that is an accurate representation of feeding which you observed on Unit 3 during your tour and again examples of what you described.

A. Yes. It shows an individual eating with the hands very rapidly, the first photograph does; and the second photograph shows her not only eating from her tray but from the tray of the child sitting next to her.

There is no way in this situation, No. 1, to control the adequacy of the diets of the people here. There was no portion control to begin with. When it

was put out it was esssentially the same amounts that each tray began with, whether you were little,
[2-73] large, fat, thin, or what, with the additional hazard of someone else always eating your food.

It was just virtually impossible to have any real diet control for the people involved.

Q. Then I take it from what you have said that careful monitoring of such diet is important?

A. Yes, it is. It is particularly important, you know, for people in a situation where they are growing, as it is with all children, all adults. It is even more important for people who have physical handicaps, for example, not to be overweight because you are adding an additional burden to the physical handicaps that they already have.

Q. Is it also important in terms of simple malnutrition?

A. Oh, of course, yes.

Q. Dr. Clements, from your evaluation of Pennhurst were you able to ascertain whether the environment was such that there was a lack of appropriate programming areas, areas in which activities could be conducted?

A. Yes and no. In many situations there were too many people and too few spaces.

In other situations there were spaces that were unused. For example, on several occasions we went down to the area that was supposed to be utilized for physical therapy and at no time that I went there did I find any activity going on.

In other areas, particularly on the living areas, where, in fact, most of the individuals were at the
[2-74] time of our visits, the spaces were too few. One of the problems that you get into with that situation is this — I don't care if you add a hundred employees in one of these large day rooms with 15 or 20 or 30 people, you still couldn't accomplish anything other

than control of the situation, which many times would be an improvement.

What I am saying is you couldn't break groups down into small groups that could relate to an employee as a person, as another individual, because it was noisy and there were no dividers and there was no equipment to do this.

The problem, the ultimate problem, that you get into in this situation is that many retarded people already have a handicap relating to each other as people. They simply are not able to develop the interpersonal relationships which you and I would.

In a home, where there is a mother and a father and several children, it is confusing even there because several people are giving them signals day by day. Some of them are contrary. The mother may be saying one thing, the father another.

But in a situation like you have at Pennhurst, where you may have 15, 20, 30 individuals living in one area and that many employees that you are dealing with on a 24-hour basis, on three shifts, it becomes virtually impossible to develop any kind of interpersonal relationship and the confusion is im-
[2-75] measurable because you may have, in the course of a day, a hundred people telling you to do different things differently and it is just not a situation that is conducive to learning.

Q. Does your answer suggest conditions which would be more conducive to learning?

A. Well, I would say that with a situation with 25 people living, or if you improved it to 20 people living, it would be much better if you could improve it to five or four or three.

Q. In other words, the smaller the group the more efficacious the treatment can be?

A. It makes it — it makes possible for better treatment.

Q. Dr. Clements, I now refer you to Photograph No. 13 on Page 7 and ask you if that's an accurate representation of the basement motor training area in the D Building.

A. Yes, it is. I referred to this area a few minutes ago when I was talking about going to this area several times and never finding it in use.

Again, it is a large area which has been an attempt at subdividing the space with sheets or other material. Again, it is an inadequate area for the purpose that it is supposed to serve.

Q. Was it empty during the times of the day when you would have expected to find residents there?

A. Yes, it was. In fact, we got a schedule of the times that the area was supposed to be in use because I was particularly interested in seeing what was going on there and, as I recall, we went there three different times and it was not in use.

[2-76]

On one occasion there were several employees there but no residents.

Q. On the basis of your evaluation did you determine that generally throughout Pennhurst there was a lack of programming activity going on while you were there?

A. Yes, I did. It is obvious when you go to the residential units where people live and they are there and they are not in programs, they are not in organized activity. I think the situation was obvious.

Q. Dr. Clements, I now refer you to Photograph No. 14 on Page 7 and ask you if it is an accurate representation of the conditions on D-3 that you showed us before.

A. Yes, it is. It shows a child sitting on the floor who appears to be digging material off the floor. Again I think this is just symptomatic of much of what was not happening at Pennhurst.

The child is unsupervised, apparently has noth-

ing else to do, is spending its time in the best way that it can, that is, simply picking up material off the floor.

Q. Is this actually a dangerous activity?

A. Yes. it could be ingested.

Q. Dr. Clements, I now refer you to Photograph No. 23 on Page 12 and ask you if it is an accurate repre-

[2-77] sentation of the residents you viewed on Ward 52 during your tour.

A. Yes, it is. This is a young man who is simply lying on the floor of a day room in the middle of the day, apparently with nothing else to do.

The head is blocked out in the photograph. I don't know whether the individual is asleep or not, I don't remember.

Again, it is an example of lack of organized programs and activities.

Q. Is Photograph No. 24 below a similar accurate representation of the inactivity on Ward 52?

A. Yes, it is. It shows another individual. Again, he is lying on the floor unattended, untouched by this program.

Q. Did you observe these kinds of inactivity, if you will, throughout the institution during your tour?

A. Yes. They were not limited to that area.

Q. Can you draw a conclusion on the basis of these observations?

A. Well, one would have to immediately assume that there were not organized programs going on at the time of the visit.

Q. Dr. Clements, did you also have an opportunity to review individual patients' records at Pennhurst to determine whether these records supported your conclusion that there were inadequate individualized programs going on?

A. Yes. The part of the records, No. 1, is an evalua-

[2-78] tion of what this individual needs. The records des-

ignate the priorities, what do you attempt to do first with a certain individual.

Now what that has done, it has to be explained on the record in language that ordinary people can understand. It is also a 24-hour record or should be of activities of this person leading toward accomplishment of the goals, those priorities that you have already determined.

Without this the only assumption I can make is, No. 1, the evaluation did not occur; and, No. 2, there is not a real or realistic plan of treatment for that individual.

Now in addition to what I have already said there should be observation, documented by the staff, of how well this is working or is this occurring; so there is no point, for example, if you are teaching an individual to tie his shoes, what he learns to tie his shoes, there is no point in teaching him to do that for another 25 years.

So the record really is there to assist everyone who has any relationship with this record to assist that resident in increasing his skill. That is the purpose of the record.

I did examine a number of records at random. Those records were chosen for me by the staff of Pennhurst. I did not select which records that I was going to examine.

Q. In your opinion, are individualized treatment plans for each separate individual necessary in order for the habilitation process to proceed?

[2-79]

A. Yes.

Q. Could you give us from the records you have reviewed a couple of examples of how the records either don't contain such a plan or are deficient in terms of currently-accepted professional standards for that kind of records?

A. Well, the records were inadequate and incom-

plete. For example, they list — one record listed as a short-term goal, and a short-term goal is independence and prevent injury.

The method stated to do that, to accomplish those short-term goals, is dressing, bathing, and safe environment.

There is nothing there that I could utilize really if I went in and had to care for that resident that would tell me how to accomplish a short-term goal of independence and prevent injury for that resident.

The long-term goal is to prevent stasis edema, increased socialization.

The method is good nursing care, foster grandparents, UAS, sewing and cooking classes, eventual transfer to appropriate ward.

Again, there is nothing there that would help me to know how to assist the resident in accomplishing those long-term goals. In other words, the records are of no benefit.

Another one that I looked at, the short-term goal was decrease hyperactivity. The method was
[2-80] daily recreation with foster grandparents.

Long-term goal — maintain present health status. The method of doing that is medicines given properly, keep bowels open, good skin care.

An observation about this individual for whom this plan was developed is has been resting well at night. Still quite active in dining area. Slides chair all over floor area to get close to other residents in order to rip strings off their gowns. Just loves to sit and play with strings.

I don't see anything in that observation that really gives you any followup in what you had said that you wanted to help that resident accomplish.

Those are not atypical of the records that I examined.

Q. In fact, they are representative?
A. Yes, they are.

* * *

[2-82] Q. Dr. Clements, in your opinion, are there certain control measures which institutional personnel resort to in lieu of efficacious programming activities?
A. When you have a situation again dealing with large numbers of people, a short staff, you have injuries, you have accidents, you have all sorts of things happening.

One of the things that you have to try to do is to get the situation under control so that you don't — so that the incidence of all of these things that I have mentioned doesn't increase.

Without adequate staff and without an adequate treatment program there are certain other things that people tend to do in lieu of that staff and treatment program. One is physical restraint. Another is chemical restraint. Another is psychological restraint.

But very often these things are used not as a part of a treatment program *per se*, and they can be
[2-83] a legitimate part of a treatment program. They are used instead of treatment.

For example, if a resident is hyperactive, to decrease the problem with that they give them a lot of pills to the point, generally, though, that the individual is groggy; and an individual who is sleepy can't learn, can not utilize what skills he has already developed.

Or you can use a physical restraint in which an individual is tied down and can not get up to move about.

Again, an individual who is tied down can not go to places where one would learn, can not use the skills that he has learned.

If he is in a bed he is restrained and even though he is toilet-trained the bed becomes a toilet. He can't get to the toilet.

So these are the things that happen. Sometimes they are necessary as a part of the treatment program, but these are the things that happen instead of a treatment program if you don't have an adequate environment and you don't have an adequate staff.

You see, the tragedy of all this is that much of these behaviors that we are trying to cut down on are really situational disorders. The behavior is a reaction to the situation that you find yourself in.

If you look at any of the standard textbooks, for
[2-84] example, in Pediatrics, Nelson's textbook which is published here in Philadelphia, you talk about headbanging, you talk about biting, all of these things that we so commonly see in institutions.

The textbook says that these are generally situational disorders, and what is the treatment? Correction of the situation that you are in — not pills, not physical restraints.

So we are creating a condition in this situation that treatment is inadequate.

Q. Do you have an opinion that those measures are being resorted to at Pennhurst as control measures?

A. Yes. In my opinion, they are.

I know of nothing, no other thing that they could do at the moment, I would say, except that it is a matter of trying to bring the situation more under control because they didn't have adequate facilities to do the job that they should have been doing.

As a matter of fact, there were a number of people at Pennhurst, as I well know, at the time of my visit that shouldn't have been there to begin with; and many of these people were reacting to a bad, inhuman, almost intolerable living setting and many

of these behaviors that I have just talked about were developed because of the setting.

Q. When you say that there were people there who didn't belong there, could you describe the kinds of

[2-85] persons, the characteristics or whatever that they possessed?

A. It would be much easier, I suppose, to try to describe the characteristics of a person that belongs there rather than one who didn't belong there.

Q. All right.

A. As a matter of fact, I didn't see, during my visit to Pennhurst, a single individual that should not have been in a less restrictive setting.

Q. Away from Pennhurst?

A. Yes.

Q. Now you mentioned when you were describing the use of these control measures that under some conditions they could be a legitimate part of an entire treatment program?

A. Yes.

Q. Could you please describe how these measures are used appropriately, as you mentioned?

A. There are a few cases, a few conditions in which an individual is self-abusive, that is, an individual may repeatedly hit his eye to the point that the eye will become non-functional, the individual will become blind.

For example, in the (Lexnihan) syndrome, that is a part of a condition of self-abuse. You have to use restraints in that condition because you weigh the consequences.

The consequences of being in restraint are less drastic than an individual continuing to injure him-

[2-86] self, blinding himself, but these are very rare situations.

You have other situations in which an individual needs temporary assistance with chemical con-

trol. The entire idea is to provide that temporary system with chemical controls to enable the person to take advantage of the other programs that are offered and by doing so hopefully no longer need the chemical control.

But when you provide the chemical control without the other program the only purpose for the drug is simply control and you are going to have to continue the drug because you have nothing else to offer and these drugs are not without dangers.

Some of the results are irreversible. Some of the drugs —

Q. I take it from what you have described that these devices, if used at all, should be used under careful control, for short durations of time, in conjunction with an active activity-type-of-treatment program?

A. That is correct. For example, if you take a physical restraint, if you tie someone's wrist, you have got to check it repeatedly to make sure it is not too tight, because if you cut off the blood you can destroy the extremity.

It takes an extraordinary level of staffing and expertise to properly use restraints. It takes an unusually knowledgeable staff to properly use chemi-
[2-87] cal restraints. It takes more staff to properly use them than to not use them, so really, if they are used as an adequate treatment method, it is going to take more staff rather than less.

On the other hand, when you see it most used, unfortunately, is where you see the least staff, the least program.

Q. Can the use of physical restraints result in injury?

A. Yes, of course, it can.

Q. I refer you to Photograph No. 18 on Page 9 and ask you if that is an accurate representation of a resident in restraint on Q-1.

A. Yes, it is. These are vinyl or leather hand restraints, in which both hands are thrust into the restraint, in which the resident obviously cannot remove his hands from the restraint.

Q. Is this a potentially-damaging situation?

A. Yes, it is.

Q. How come?

A. Well, obviously, the resident can not learn, or if he learns, can not do certain things for himself.

How would this resident go to the toilet unassisted? How would this resident attend a class?

How would this resident fend off the attack of another resident?

Q. Dr. Clements, do you have an opinion regarding the use of certain tranquilizing drugs commonly used in institutions in lieu of efficacious programming, as you already testified?

[2-88]

A. Ask that question again, please.

Q. Do you have an opinion as to how certain tranquilizing drugs are used in institutions in lieu of efficacious programming?

A. Well, yes. I think they are essentially overused in many institutions, including Pennhurst.

The Federal Drug Administration, up until about a year ago, never approved psychoactive drugs, tranquilizers, for behavior control of retarded people; so, as far as the FDA was concerned, there was no approval at all.

This is not to say that retarded people don't become emotionally ill or mentally ill as well. Unfortunately, we don't use drugs adequately for that class of people.

For example, if you take the retarded person in a situation like this, who is depressed rather than hyperactive, that person is likely to get no attention at all. He does not get "the benefit" of a drug.

On the other hand, if that person is running

around, hitting other people, spitting, or other things, regardless of whether that person is mentally ill and whether that drug is treatment specific for that condition, that person is likely to be tranquilized by a drug.

My survey of institutions in the United States shows the average percentage of people in institu-
[2-89] tions for the mentally-retarded runs about 55 percent of all people in those institutions. Generally, they are not kept on one tranquilizer but on several.

I don't know percentage-wise how many people or what percent of the people in institutions should be on drugs. It is certainly much closer to 25 percent than 55 percent.

It would have to be determined on an individual basis, depending on the individual resident's needs.

Q. Did you get an impression that drugs were overused at Pennhurst?

A. Again, I would not be willing to say that any specific individual at Pennhurst is incorrectly on a drug because I didn't look at it from that standpoint.

I do have figures here in my report somewhere to give the discrepancies that I found when I randomly found that certain units — and this is on tranquilizers — for example, in Ward C-7, 65 percent were on tranquilizers, and on Ward C-8, 54 percent; on Ward C-9, 25 percent; and on Ward C-10, 50 percent.

You know, it is a very interesting phenomenon when you look at the institutional population and the use of drugs. You will find a very nice figure of ambulatory people on tranquilizers.

If you look at the non-ambulatory group, that is, that are confined to bed, there is an extraordinary low figure generally in institutions; and my only conclusion is I don't know why people in bed should
[2-90] need treatement more or less than people who are not in bed.

My only conclusion is if you are in bed you can't get up and raise hell and the only reason that most people are on tranquilizing drugs in institutions is because you are raising hell.

* * *

[2-93] Q. Dr. Clements, what are your major impressions and recommendations for Pennhurst based on your review of the facilities?
A. My impression as listed in my report is really that the major problem that we are dealing with at Pennhurst is that it represents the wrong concept, at the wrong time, and in the wrong place.

Pennhurst has, in my opinion, outlived its usefulness to the retarded citizens that it attempts to serve.

The environment at Pennhurst, both physically and psychologically, is totally counterproductive to even adequate custodial care. It is entirely unfit for the purpose of habilitation.

[2-94] There is overcrowding, inappropriate environment, and lack of habilitation programs, which result in physical, psychological, and emotional deprivation and in most cases immediate hazard to the safety and wellbeing of the residents, as well as physical, social, and emotional deterioration of the residents.

There is a drastic lack of facilities. The physical structures are inadequate.

There is an inadequate complement of direct-care personnel on duty. Middle management is spread beyond its ability to offer effective managerial support. Adequate quality and quantity of professional staff is not available.

Programs of habilitation are not available in adequate quantity to prevent continuing physical, emotional, and social regression.

Physical and chemical restraints may be substituted for lack of programs and adequate environment.

My feeling after visiting Pennhurst is that a majority of the residents, provided proper community resources were available, could be placed back in the community and reasonable progress for the residents could be expected to occur.

BY THE COURT:

Q. Would you explain what you mean by "placed back in the community"?

A. Yes, sir.

[2-95] We often get frightened at the prospect of people being suddenly and abruptly removed from institutions and dumped back into the communities. A second frightening aspect of this is the specter of spiraling costs to provide these programs.

By placing back in the community, I think that the process should be, No. 1, each resident at Pennhurst would be evaluated on an individual basis to know what that individual's strengths and weaknesses are. A determination will need to be made of what programs would be beneficial to this reident, as well as the type of environment that would be most conducive to that resident's progress.

Once you know that a determination could then be made of what resources you already have at Pennhurst could be reshifted back to the community.

For example, it should not cost the State of Pennsylvania enormous sums to do this if they will utilize the resources that they already have at Pennhurst and redirect those resources into more corporate programs.

The most important single thing that will be accomplished for the residents, No. 1, is a more decent situation in which to live and a situation in

which we will make it possible for that resident to receive and benefit from adequate treatment.

It is my opinion that if you supply everything that you should want for Pennhurst today you [2-96] would end up with a situation that would bankrupt the State of Pennsylvania; you would end up with a situation in which you basically had control, you could control what was going on there.

I don't think that you would end up with a situation that would be decent to live in nor a place that would be conducive to treatment of the residents living there.

When you put people together in a situation like this, large groups together, you just increase the handicaps. People model their behavior from the behavior to which they are subjected.

Your Honor, there is simply no way that I know that you can prepare a resident of Pennhurst to go back into the community by anything you could do at Pennhurst. To prepare the situation in that community you redistribute the resources that they now have at Pennhurst to the community and then you will have a system of community programs and you won't need a large institution at Pennhurst.

* * *

[2-99] Q. Let me ask you then, Doctor, without going through the specific pictures — there were several there, several of the pictures in the exhibit that was shown to you, getting back to what you said about several of them represented children or people, retarded people, with spastic conditions.

It certainly appeared from those photos that at least in several instances people appeared to be bedridden, practically.

A. Yes.

[2-100] Q. How would we take care of them under your plan in the community?

A. First of all, if you compare the difficulties of caring for a person like this compared with certain other people, for example, I don't think it is as difficult to care for a person, if you use the term "bedridden," as it is a person running about and hard to keep up with. I feel it is less of a problem.

You do realistically, though have to have certain provisions in which you can get physical therapy, et cetera, and you can be taught in the home to do certain of these physical-therapy features.

It may be necessary during certain hours to send in a home-nursing service to dress the person, get them out of bed, bathe them, put them in a wheelchair — that sort of thing.

Q. Then I do understand that you are saying that the community concept that you are advocating is one that would provide a residence in presently-existing homes?

A. I think that would be the most appropriate situation, Your Honor.

Q. In other words, you are not recommending or suggesting building facilities that may in some way resemble the present institution that you are now the head of, or resemble Pennhurst, but on a smaller scale in each community?

A. I would strongly advise against it.

Q. Then how do you justify, for instance, the exist-

[2-101] ence of the institution that you are now heading, and I don't mean that as a trap question? I just wondered how that would fit in.

A. I don't justify it, Your Honor. In fact, what we are doing at the present time is, in the development of community programs in Georgia, we know that there are not going to be substantial State dollars available to do this, so what I will do, for example, I

will contract with a local community and I say to them if you can make placements and maintain four or five people in your community, then I will give you these two or three jobs to do it.

It would have been necessary to have them in the institution to care for these people. You can use the job, you can use the money that goes with it, and this will maintain in the community more people than the same dollars would maintain within the institution.

* * *

A. It is in Atlanta.
Q. Right in Atlanta?
[2-108] A. Yes.

My last recommendation is to discontinue all admissions, new admissions, to Pennhurst.
Q. Dr. Clements, have you had any experience in the implementation of the kind of recommendations that you have made for Pennhurst?
A. Yes, I have.
Q. And could you describe briefly for the Court what those experiences have been?
A. I guess the most intensive experience has been with the order in New York State relating to Willowbrook. At the present time I am chairman of the Willowbrook Review Panel, which is an arm of the Federal Court in the Eastern District of New York, which was appointed by Judge Judd to oversee the implementation of the court's order.

The implementation of it is the most difficult part of the litigation. The problem has been turning around a State system. There is no way that we have been able to make Willowbrook a good place to live.

The annual budget at Willowbrook at the present time is $70,000,000 per year. Even with

that $70,000,000 and literally thousands of new employees it is still not a good place.

[2-109] The most dramatic improvement at Willowbrook has been due to one thing, and one thing alone; and that is a decrease in the population.

MR. GOLDBERG: Your Honor, I can't hear the witness.

THE WITNESS: It is a decrease in the population of Willowbrook.

It is my feeling at this point, after being involved in this for several years, that with very little more money Willowbrook had in the beginning, very few additional employees, but had the population decreased as it has done at the same time the results would have been the same as they are today.

So the critical issue is the decrease in the density of the population in which people live and I would say that that, in and of itself, is the most critical factor at Pennhurst. It is far more important than generally the lack of resources that I described.

BY THE COURT:

Q. Now at Willowbrook has there been or was there, I should say, a determination that in the future more people should be treated in the community —

A. Yes, sir.

Q. — or housed or reside in the community rather than at Willowbrook?

[2-110] A. Yes, sir. When the Willowbrook case first came about there were 6500 people — 6,500 people — at Willowbrook. It was the largest institution for the retarded in the world. It is located on Staten Island.

The order states that the population of Willowbrook shall be decreased down to not more than 250 remaining people there at the end of the jurisdiction

of the court. All other people shall be in community programs, living in the community.

Q. Let me ask you this:

How long have you been associated with that court decree?

A. I have been on the Review Panel since July of '75.

Q. Did the implementation of that decree, if you know, require any legislation as far as the State or the Federal Government or the local government?

A. No, sir. The important of what we have learned there is this — you have to have some mechanism to follow up on the order, not that you are implying that people are untrustworthy. The problem is the people who are trying to carry out the order very rarely need a quarterback for them.

You see, you are existing in a situation of conflict of interests, with certain orders in a system initially.

What I think that we have been most helpful in doing, that is, the Review Panel, is to provide expertise to the people in the Department of Mental Hygiene in the State of New York and to also assist them in doing what needs to be done. We have been able to take a lot of the flak off their backs, in other words.

[2-111]

We have had a fortunate situation in that the State of New York also wanted to implement that order and was sincerely committed to do so and the Review Panel and the State have been able to work together toward trying to get it done, but it has meant a turnaround of the direction of mental hygiene.

Q. I am going to ask you the same question I asked your predecessor on the stand — I don't know whether you were here or not — but during your visit to Pennhurst and your opportunity to confer

with the superintendent and the staff generally, did you discuss this type of community programs and what you think is the proper determination to return these people for residency in the community?

Did you discuss that with them?

A. Yes, sir, I did.

Q. Generally speaking, did you find much opposition to your recommendations?

A. As I recall, they were certainly strongly supportive of the development of the community program as I was.

* * *

[2-124] Q. One other thing in your testimony, Doctor — at one point you said that, in your opinion, 100 percent of the residents of Pennhurst could be placed in a community facility if an appropriate one existed; and at another point you said, I believe towards the end, that some persons may have to stay at Pennhurst, the multiply-handicapped who need continuing medical care.

Just for my own clarification, which is it? Could they all be put in the community or would some have to remain at Pennhurst?

A. May I quote myself accurately?

I said I didn't see anyone at Pennhurst that I didn't think could be in a community program. That was the first quote.

The second quote was I said the last individuals, in an effort at depopulation, the last individuals that I would see remaining at Pennhurst would be those that required constant and continuous medical and nursing assistance in order to survive.

Q. Would they have to stay at Pennhurst?

A. No, they would not.

* * *

Testimony of Allen Taub

* * *

[2-139] BY MR. FERLEGER:

Q. Mr. Taub, would you state your age and occupation, please?

A. I am 56 years of age and I am a partner in the meat business.

Q. Have you, in the past years, had any involvement on any official or formal basis with Pennhurst State School and Hospital?

A. At the present time I am president of the Parents and Family Association of Pennhurst. I am also a member of the Parents Staff of Pennhurst; also a member of the Woodhaven Center at the Woodhaven State School, and I am residential chairman of PARC, Philadelphia; also, I am a Board member of the Philadelphia Association for Retarded Children.

I have also been on investigation committees out at Pennhurst, one with Stan Meyers, rather, Mr. Miller, Stan Miller, and also represent CO-MHAR out at Pennhurst and also had the honor of picking the two superintendents for Pennhurst.

* * *

BY MR. FERLEGER:

Q. Mr. Taub, do you have a retarded child?

A. Yes, I do, my daughter, Linda, who is 26 years of age.

* * *

Q. You, on behalf of your daughter, have participated as a plaintiff in this lawsuit?
A. Yes, I have.

* * *

[2-145] Q. What made you decide to turn to Pennhurst for the care of your child?
A. Well, Linda went to a few different schools and we just believed in home environment and, you know, we thought that Linda — we just couldn't let go, that's what all parents do, self-denial. We just don't want to accept the fact that one day you have to make that decision.

Linda was at the age of 15 years of age and we went through quite disturbing nights and sleepless nights and this is something that people don't understand unless you have a retarded child, the emotions, the family strain, the draining, you live abnormal. It is not a normal way of living.

[2-146] Consequently, if we went somewhere we would always have Linda on our minds and we were called from places to come home. It was chaos.
Q. Who was taking care of your child at home?
A. Well, my son. I had a son, Gregory. He was helping out.

We tried to get some babysitters and they would go as far as they can and then they would call and we'd have to come back.

But it got to the point where it is either a nervous breakdown for the entire family or for my wife or myself. Besides Linda being home for 15 years, we got to realize that we, as people, as her parents, have other children, plus the fact that we have other obligations and we had to live our own lives too.

And it came to the point where we had to make that decision and we finally decided that there was no other recourse but an institution.

Q. At that time was there a waiting list for admission to Pennhurst?
A. At that time Pennhurst, as everybody said, there was a waiting list of over 2,000 people waiting to get into Pennhurst.
Q. And did you put Linda on that waiting list?
A. We put Linda on the waiting list and we waited and finally she was admitted.
Q. How long did it take?
[2-147] A. It took maybe around six to eight months.
Q. At that point did you know what sort of program or situation Linda would go into?
A. Well, at that point I would say the family was at the point of desperation and at that point any recourse, any avenue to turn to, would be welcome; so it was just going into a blind situation.

The most important thing was to give what we call now respite care to that family. The family needed help and that was the only place to turn to get it.
Q. Okay.

And did you have any difficulty making that decision?
A. We didn't sleep for nights and we didn't sleep for days. It was one of the most nervous times of my life and it was very upsetting.
Q. Why was that?
A. Because we believed in family, parents, home environment; and we just didn't want to leave go, I guess, but we had to.
Q. When was Linda admitted to Pennhurst?
A. Linda was admitted in 1966.
Q. Do you remember the month?
A. It was October; either it was October or November.
Q. Did you and your wife take her there the first day?

A. Well, I could say that was one of the saddest
[2-148] days of our lives, when we took Linda to Pennhurst. It was a rainy day and it just was in my mind.

We rode. Linda was in the middle, between both of us, and we took her out of the house at 8 o'clock in the morning and it took us about an hour — an hour and a half to get there and we cried. We cried until we got there and that's the way it was.

Q. Now did you go with Linda to the ward that she was admitted to or not?

A. Well, when we came there, there was a little waiting room and the usual hard bed and we were in the lobby waiting for someone to come down and take her.

Q. In the administration building?

A. No. This was in another building. I guess it might have been in T. I really don't know if it was in the hospital unit, but we were in a little lobby, like.

Q. Were you permitted to go to the ward with her?

A. No. We left Linda there.

A person came down. In fact, I would say the social worker most likely, I believe, Mrs. Marshall. She came out and greeted us and they took Linda and that was — that was it.

[2-150] Q. Were you permitted to visit there?

A. C-1 Unit was the worst unit that I have ever encountered. C-1 Unit was a place where you had to come up the steps and you had to bang on the door for maybe half an hour before somebody would come out and let you in.

Q. Do you mean that literally, a half an hour?

[2-151] A. Literally. By the time of the banging on the door, and again people don't seem to understand that people, parents, have feelings when they go into a place like that on the beginning, to get acclimated.

You have to visit and you have to keep banging and banging and no one answering, that was very annoying.

Finally, that caused the bell system to be originated in Pennhurst, so when you came later on you would ring the bell, and this is what parents had to interject into the institution to at least give us the courtesy when we came, don't let us wait, we will ring the bell so people there will know that we are here and they will come out to the door.

Q. Do you recall your first visit to that ward? Will you describe the ward to us?

A. That ward you normally didn't get into. That was a closed ward, but one day I got into that ward and it was what you would call, you know, being into a situation like this for the first time, just like you would see White zombies, people walking around like that in an enclosure, all in straitjackets, and walking with their arms all tied up.

And I was wondering where my daughter was and there was Linda on the floor, in a straitjacket, just sitting there on the floor.

Well, my first impulse, the first time I saw that, it was like traction, the worst I saw —

[2-152] Q. Now did there come a time in 1968 in the fall when Linda was in a wheelchair at Pennhurst? Will you describe that?

A. Well, Linda, finally, after very hard maneuvering and I was very lucky, we were able to get here out of C-1, which I call the snakepit. That was one of the worst wards I have ever seen.

We managed to get here out after several months of trying and we got her into C-8, and C-8 was a lot better.

One day we came up to visit Linda and you walked right up, and I couldn't find my daughter. Me and my wife were looking for her. We just couldn't find Linda.

And we passed by this little girl and then we realized that that must be Linda, and she was in a wheelchair and her arms were strapped around and

they were in a position where she couldn't get out of the wheelchair.

Q. Now was Linda a person who was able to walk?

A. Linda was able to walk. Linda was blind but walking was not a problem.

Q. What was she tied to the wheelchair with?

A. Well, it seemed like, you know, the whatyoucallit, the straitjacket tied around and she was just with her head down, and one of the things, the coloring on her face, you know, I believe in exercise, I believe people should be walked around.

But her face, her sallow complexion, being in a wheelchair, being tied up, that left a harmful image.

Q. Did you ask any staff why she was tied up in a wheelchair?

[2-153] A. Well, we asked and it seemed that that was the best thing they could have done with her at that particular time, that that was the best thing for her, that particular setup, because she was constantly being turned around.

They felt that putting her in this position they would know exactly where she was.

Q. That would keep her from walking around?

A. Well, that's the way it seemed at that present time.

Q. Now during the period of time that she was on C-8, which was until April, 1970, from 1968, could you describe any programs that Linda was involved in?

A. There was about maybe one program as far as I could actually realize. That was like a feeding program, trying to develop her eating potential and trying to get her eating habits developed.

Q. Was there any other program that you know of?

A. As far as I would say, very little programming.

Q. How did Linda spend her time?

A. Most of the time, as these two gentlemen here, witnesses, described, it was sitting on hard benches.

One of the things we protested more than anything else was the garment that stayed on and half the time with no undergarment, and exposed; no shoes. The feet would be one of the worst you could see. Everybody walked around barefooted.

Q. Everybody on the ward?

[2-154] A. Most of the people in the ward had no shoes.

Q. What proportion were clothed or naked?

A. Well, you had a percentage of people always taking off their clothes and you had people sitting on the hard chairs naked.

I mentioned quite a few times some of these chairs, if you ever visit, some of them weigh 50 or 75 pounds of hard wood; and when the kids would get hyperactive in some of these cottages, they got power, they got strength, they throw the chairs over.

And talking about kids getting hurt or why, you could just be walking by at that particular time and the chair would come over and it sure could break an arm or a leg.

I mentioned many times that they ought to replace those chairs, those hard rock chairs, with something a lot softer there. That doesn't require much money.

* * *

[2-159] Q. According to the records, Linda went to Ward I-1 in May of 1970 and stayed there until September, 1973, when she went to Ward H-1.

Could you describe the conditions on Ward H-1 in 1973?

A. Ward H-1, I think the unit system at this time began to become a little effective and the population

here was a lot reduced. There might have been maybe 30 in the cottage, I am not sure, and we had — there was an old building that had to be constantly renovated and fixed. The bathroom facilities for some reason always seemed to be the worst in Pennhurst and, as the gentleman said here before,
[2-160] there were cracks on the floor and water deposits. It was very easy to slip and just fall, which happened over and over again, and the same constant no-program.

Q. What was the condition of the toilets?

A. Well, the toilets — you never had toilet seats.

Q. No toilet seats?

A. Yes. You sat right on the bowl and you sat on the cold bowl and some kids would sit there for hours, just sitting there with their feet up.

And we are talking about maybe one or two attendants with around 30 people.

Q. And what would the attendants be doing while the residents were sitting on the toilet bowl?

A. Unfortunately, there is so much activity to be performed with two people that it was totally impossible to really know what was happening in the front and the back.

The physical structure was completely no good for two attendants to observe.

Q. Would residents be left unsupervised?

A. Residents were left alone. If you don't bother me, I don't bother you; and this is the sort of setup you had.

The resident would go into a bed in the back and lay there for an hour or two, I mean, that's the way the setup was, because that was due to the lack of help. They just couldn't get around and get these people out.

[2-161] Another thing a lot of the kids would do is there was a constant banging, you know, where they would just hit their heads on the wall.

Q. And what would the residents do in response?
A. When you say "residents," we are talking about—
Q. I mean aides. What would the aides do in response?
A. The aides — everything was taken — a lot of things were taken for granted, that this is the way it should be.
Q. When a resident was engaging in head-banging what would the aide do?
A. Well, they'd be busy. They would be preoccupied with other things and we used to — we played the role of father. A lot of people never had parents that would come and we would say to them stop, and I asked many, many times for what we would call a child-care attendant aide on the ward.

This type of aide would be just walking around and her job was to see that the abuses would stop.
Q. The aides weren't engaged —
A. The aides didn't have the time; they just couldn't handle that situation.
Q. Were children ever lying in bed with any material that shouldn't be there?
A. Well, that you had. You had children that unfortunately, like the gentleman said there, when they had to go when they were in bed that was the thing that happened.

* * *

[2-169] BY MR. FERLEGER:
Q. Did he provide any care to Linda Taub?
A. No. We brought his report back to Pennhurst.
Q. And did you see that report?
A. Yes, and then —

BY MR. FERLEGER

* * *

[2-170] Would you characterize the progress or the lack of it that you feel your daughter made during her years at Pennhurst from 1966 to 1975?

A. I think there is only one way and it would seem that as far as we are concerned as parents, there was regression.

Q. Excuse me. Regression?

A. Yes, that Linda went down.

The only thing that Linda got at Pennhurst was strictly custodial care.

* * *

[3-13] **Testimony of R.L. Sprague**

Q. How is your experience in psychopharmacology uniquely involved with the field of mental-retardation?

A. I think it is uniquely involved. There have not been a great many people in this country, unfortunately, interested in this area.

I have been chairman of the FDA Subcommittee which deals with this particular problem for the nation.

I have up until recently the only research grant issued by the National Institute of Child Health and Human Development to study the effects of
[3-14] psychotropic drugs, which are the drugs given in psychopharmacology, the effect of these drugs on mentally-retarded patients in institutions.

Q. Are you also necessarily familiar with psychopharmacology as it relates to mental illness?

A. Yes, I am.

Q. Could you please distinguish between mental illness and mental-retardation?

A. Mental illness is a condition in which the person needs treatment, psychiatric treatment, because of psychotic disturbances or neurotic disturbances, usually causing bizarre or unusual behavior.

The mentally-retarded is an entirely different problem in which there is slow development, usually from birth, so that the person's primary problem is slow learning and does not necessarily involve the bizarre, unusual behavior that typifies the mentally-ill.

That is not to say that the mentally-retarded cannot also be mentally ill at the same time. In fact

there are a few mentally-retarded individuals that also are mentally ill, but that is more rare.

* * *

[3-23] Q. Doctor, did you visit Pennhurst State Hospital to evaluate the prescription, distribution and administration of psychotropic drugs?

A. Yes. I visited Pennhurst on March 3rd and 4th, 1976.

Q. What was the general method of conducting your evaluation?

A. Prior to arriving I asked for a random sample of the residents to be generated and Dr. Youngberg's secretary — a list was given to me and I attempted to visit the wards or units of each of those residents, read the medical records for approximately a year, talked to the direct-care nurses and attendants that might be in attendance on that ward; and in some cases speak briefly to the residents.

THE COURT: Let me interrupt again.

[3-24] BY THE COURT:

Q. What was that date again?

A. Your Honor, March 3 and 4, 1976.

THE COURT: Thank you.

BY MS. CHRISTENSEN:

Q. Did you also have occasion to speak with any staff at Pennhurst State Hospital?

A. Yes, I did. When I first arrived I asked for a meeting with Dr. Hedson, chief of medical services, Mrs. Helen Francis, chief of nursing services, Mr. Norman Benner, who is the head of pharmacy, and Mr. Peter LeMaire, Associate Superintendent, also attended that.

We discussed problems and policy regarding prescription and distribution and monitoring of

psychotropic drugs at Pennhurst for approximately an hour and a half.

Q. Did Dr. Hedson indicate any particular problems to you at that time?

A. The problems that were discussed involved the distribution and monitoring of the medication, how it was distributed, and particularly most of the time was spent with the training of the aides that actually administered, that is, give to the residents their medication.

Q. Did Miss Francis give you any information during that interview?

A. Yes, she did. She indicated there are problems
[3-25] with the current system they have in the sense that they are using non-professionals in the sense that they are not nurses or licensed practical nurses to pour, which is the Pennhurst term meaning that the medication from the bottle on the unit, the tablets are taken from there and placed in individual cups for the individual resident by an aide, and that aide is a person without any particular specialized training for their employment in nursing service, to give them in-service training to handle this rather difficult assignment.

Q. Did Mr. Benner give you any information regarding the drug system at Pennhurst?

A. Yes. He was extremely helpful and gave a lot of information about his work since he has been at Pennhurst.

He described the distribution system, the storage system, and he particularly had information on total usage at Pennhurst during the past five years; and he gave me that information.

Q. Prior to leaving Pennhurst did you have any opportunity to discuss your findings and conclusions with these same Pennhurst staff members?

A. Most of the same staff members, part of the afternoon prior to leaving I had an opportunity to talk with Dr. Hedson and — Mr. — I am sorry, Mr. LeMaire, Mr. Foster, and I believe that's all.

Q. And at this time did you discuss your recommendations and your findings and conclusions with them?

A. Yes. We outlined in general detail my findings and recommendations, particularly when we spent
[3-26] most of the time discussing the inadequacies in the monitoring system, that is, the system which they use to check to see whether the drugs are actually doing what they expect them to do with the residents.

Q. Did they disagree, express any disagreement, with your conclusions and recommendations regarding monitoring of the ill effects?

A. No. As I recall, there was general agreement on the inadequacy of the records.

Q. Dr. Sprague, were you provided with any materials at the time of your evaluation of Pennhurst State Hospital?

A. Yes. I requested that the nursing service give me twenty-six different guides, memoranda, and manuals.

MS. CHRISTENSEN: Your Honor, may I approach the witness?

BY MS. CHRISTENSEN:

Q. Dr. Sprague, I hand you Government's Exhibits No. 32 and No. 33.

Have you had an opportunity to examine these exhibits?

A. Yes, I have.

Q. And can you describe to me what those exhibits consist of?

A. Exhibit 33 is the material used by the nursing service in the training of medicational aides in

dispensing psychotropic medication and other medication.

* * *

[3-34] Q. Have you reached any general conclusions as to the adequacy of the medication — course-of-training materials?

A. Yes, I have. I believe they are inadequate in terms of the amount of material that is available and used at other institutions and generally available; the length of time of the training, twenty hours as indicated; and the standards for checking subse-

[3-35] quently the child-care aides in the usage of the medication.

Q. Dr. Sprague, how did you conduct your survey of individual residents' medication?

A. I tried to visit the ward where the resident lived and then talked briefly to the nurse or the aide that was there, and then reviewed the medical records, the doctor's orders for the last year, particularly noting the medications that had been given or no medication; the reason it was given and the monitoring or the checking for the effects of the medication during that year.

Q. How many residents on the random sample did you actually review?

A. Thirty-nine.

Q. Do you consider that this is a statistically-representative approach?

A. Yes, I do.

THE COURT: May I interrupt to ask a question?

BY THE COURT:

Q. Were you able to obtain any figures as to the number of residents at the time you were there in March of 1977 to whom, I should say, these drugs

— and when I say "these drugs," of course, I am referring to the psychotropic drugs — had been administered?

A. Yes, your Honor. I calculated that information and of those residents, 51 percent were receiving psychotropic medication.

Q. 51 percent at the time you were there were receiving it?

A. That's correct.

[3-36] Q. Did you have any information that would indicate what the percentage would be concerning the number of residents who had, during the period that they were there, received this type of medication?

A. No, I didn't examine the records. I can only assume, basing on the residents' charts that I evaluated, what might be true; but I did not — I don't have that over a period of years, how many might have received medication.

Q. The figures that you received then, I think you said 51?

A. 51 percent, your Honor.

Q. 51 percent of the residents that were there at the time, March 3 and 4, 1977, were receiving these drugs?

A. That's correct.

THE COURT: All right. O.K.

BY MS. CHRISTENSEN:

Q. Dr. Sprague, going further, what percentage of the residents that you reviewed received anticonvulsants?

A. 35 or almost 36 percent.

Q. Did you determine what percentage were receiving both psychotropic and anticonvulsant drugs?

A. Yes, I did, and that was 30 percent receiving both the psychotropic and the anticonvulsant.

Q. What percentage of the residents you reviewed were receiving two or more psychotropic drugs?

A. There were 40 percent of the residents receiving

[3-37] psychotropic drugs that were receiving two or more of the drugs at the same time.

Q. What is this practice commonly referred to?

A. It is commonly referred to as polypharmacy.

Q. Will you tell me what the hazards of polypharmacy are?

A. There a whole range of hazards giving two or more drugs at one time.

Sometimes the drugs don't simply add up, but they combine and create problems that would not occur if each drug is given individually. That's called potentiation interaction.

Also, there are a number of contraindications, if you look in the medical literature, that this particular drug should not be given with another particular drug, so there is an additional hazard of giving several drugs at one time because of that.

Finally, if one is attempting to assess, to monitor the effects of the medication on the residents, and again that is the reason given, it is next to impossible to figure out which drug is causing what if there are several being given at one time.

Q. Doctor, do you consider that the percentages of drug usage which you outlined previously — 51.3 percent on psychotropic medication and so forth — did you consider this percentage significant?

A. Very significant — high.

BY THE COURT:

Q. What was the last word? I didn't get that.

[3-38] A. Pardon me — high, quite frequent use.

Q. On what do you base that statement?

A. I base that opinion on survey work that I have done in the country and some overseas, and my visiting other public facilities for the mentally-re-

tarded, and most particularly recently the Georgia Mental Retardation Center for the most disturbed ward, where the most severe problems occurred, and 25 percent of the patients were receiving medication.

If you would look at the total facility the frequency would be much lower than 25 percent.

BY MR. CHRISTENSEN:

Q. Doctor, is that mental facility the same facility run by Dr. James Clements?

A. Yes, it is.

Q. And are any of the wards on that facility comparable to the wards that you observed at Pennhurst?

A. Comparable in the sense of the degree of severity of the problems and the recurrent behavior.

Q. Doctor, did you observe any trend in drug sales at Pennhurst Hospital?

A. Yes, I did. There were two trends.

The total usage of Thorazine and Mellaril had declined over the past five years, but unfortunately the usage of the three other or four other medications had rather dramatically increased during the past three to four years.

[3-39] Q. The figures on which you are basing your determination as to these trends were provided to you by Mr. Benner; is that correct?

A. Mr. Benner, that's correct. Mr. Benner kept this information and volunteered the information to me.

I went to see him; he pulled his records and gave me this information. I wrote it down and then calculated the total usage.

Q. And from the figures which Mr. Benner had given to you from Pennhurst State Hospital — from the figures that he gave to you what were the percentage increases in these drugs — Haldol, Prolixin, and the last one?

A. Haden in the last few years increased 900 percent; lithium in the last four years increased 800 percent or more; Prolixin in the last four years has increased 400 percent; Haldol in the last five years has increased 240 percent.

Q. Are the drugs which have increased in usage approved by the FDA for prescription for mentally-retarded persons?

A. They are approved for use with psychiatric problems. They are not specifically approved for use with the mentally-retarded.

Thus we are in a situation if the mentally-retarded are psychotic, have severe problems with depression, for example, that would be the case with lithium. They are appropriate to be used, but they are not specifically approved for the mentally-retarded.

Q. What is your professional opinion of the drug
[3-40] utilization trend that you have indicated?

A. Well, particularly with lithium, which is a medication very useful for the depressed, manic-depressed patient, I haven't seen a manically-depressed retarded individual.

I am not saying they don't exist. If they do exist, excessive numbers exist at Pennhurst, at least as indicated by the 800 per cent increase in the use of lithium.

Q. Doctor, can you give us some specific examples of problematic practices at Pennhurst State Hospital which you observed?

A. Yes, I can. I referred to some of the cases that I saw when I visited there. I catagorized them and I have given them a number.

Case 4 involves an individual who was receiving three psychotropic medications and one anticonvulsant medication — Haldol, two milligrams three times a day; Valium, ten milligrams on

a PRN or as needed order; Mellaril, 200 milligrams three times a day, which is 600 milligrams a day; and Dilantin, one gram at night.

That's interesting because the new FDA recommendation on total dosage per day for Mellaril and Thorazine is 400 milligrams, and this was 200 milligrams over that, 600 milligrams a day, in addition to the other medications that the individual was receiving.

Q. Do you have any other examples?

A. Yes. Case 7 was receiving ten milligrams of Valium as needed, PRN: Stellazine, ten milligrams
[3-41] twice a day; Mellaril, 300 milligrams twice a day, which again is 600 milligrams, above the 400-milligrams suggested limit.

Very interestingly, with this particular case there is just a hint of behavioral monitoring in the doctor's orders and what is said is good and friendly.

It puzzles me, if that is the classification of how the resident is behaving, why so much psychotropic medication.

Patient 20 received a number of psychotropic medications. I have this date January 6, 1977, he received Cogantin, two milligrams twice a day. Cogantin is a medication given to counteract some of the problems that occur because of the use of the psychotropic drugs. He received Prolixin, one cc; Benadryl, 50 milligrams at night, thereafter 30 milligrams as needed; Haldol, ten milligrams three times a day, and Benadryl 50 milligrams a day.

What is particularly interesting in this case is how the patient is evaluated for the effects of this rather extensive medication and back over the years, in every case, the reason for giving this was upset behavior.

That's certainly not a very clinical or technical description, except in one case, on February 10, 1977 it is indicated very upset.

This indicates almost a total lack of any essentially adequate monitoring.

[3-42] Case 23 received several psychotropic medications. The interesting situation is that on December 5, 1976, when shackles, as needed, were ordered for twelve hours, along with chloral hydrate, 50 milligrams immediately.

Q. Do you consider that a significant order for shackles and chloral hydrate at the same time, Doctor?

A. In my experience I am very surprised that shackles would be ordered on a PRN basis at the determination of the staff.

These are some of the more outstanding cases. Let me refer to one other, 29, where seclusion for twelve hours was ordered on a PRN basis at least twice.

Q. And what was the reason indicated for ordering seclusion at that time, Doctor?

A. Intoxication.

Q. In your experience is this a reason for ordering seclusion?

A. No, it isn't.

Q. Doctor, did you observe PRN or as-needed orders for behavior modification in the orders which you reviewed?

A. Yes. There was quite a number of that. In fact, I looked at that number and it is roughly 30 per cent where the psychotropic medication was PRN.

Q. Do you understand what the policy of Pennhurst is with regard to PRN administration of behavior-modification drugs?

A. I think I understand that.

Q. And on what do you base your understanding?

A. The memorandum written by Dr. Youngberg in 1973 outlining the policy.

[3-43] Q. And what did that document say?
A. Well, it is permitted on the basis of a prescription of a physician, if the physician has prescribed the PRN medication.
Q. Is that for a standing PRN order or just a situational order or occasional PRN order?
A. I am not able to precisely ascertain from the medical records. It would appear to be standing because there are on some occasions stat orders. "Stat" means immediately which means that there has been a call usually and a particular problem arising, so the physician will give typically a verbal order to give it immediately.

So that's responding to a precise defined situation, where many of the others appear to be standing PRN orders.
Q. What are the problems with a standing PRN order for behavior-modification drugs?
A. Well, considering the problems that the drugs have as side effects, the PRN order basically means that the drug is being used and administered on the judgment of a non-professional, and certainly not a physician. That is the staff on the ward can make the judgment whether to give or not give the medication on a non-professional judgment.

BY THE COURT:
Q. What do the initials "PRN" stand for, if anything?
A. Sorry, Your Honor, I don't remember the Latin.

MR. FERLEGER: *Pro re nata.*

[3-44] MS. CHRISTENSEN: That's correct.

MR. FERLEGER: Which means as is necessary.

THE COURT: Say it again, I want you to say it for me.

MS. CHRISTENSEN: *Pro re nata*, Latin for as is necessary.

BY MS. CHRISTENSEN:

Q. Dr. Sprague, based on your professional expertise and your evaluation of medication factors at Pennhurst, in your opinion are excessive amounts of tranquilizing drugs being used at Pennhurst?

A. Yes, on the basis of the 51 percent of the residents receiving it; on the basis of the residents who are receiving psychotropic medication, 40 percent receiving polypharmacy; and on the basis of the length of time they are getting it; and on the basis of the very inadequate monitoring of the effects, they are being used excessively.

Q. Would you characterize such usage as constituting chemical restraints?

A. Yes. I believe that's the characterization.

Q. Doctor, you have mentioned some problems with the monitoring of behavioral side effects.

Why is this important? Why is monitoring important?

A. Well, it is like many other medications that are given for a reason and, if necessary, to see whether they are having an effect.

[3-45] Psychotropic drugs are given to control behavior and it is absolutely essential to see whether they work. Not all drugs work with individual residents. Not all drugs work at a certain dosage.

So if there is an adequate necessity to continue it, without monitoring the effects of these drugs, there is no way of ascertaining whether it should be given, whether it should be discontinued, whether the dose should be increased or decreased.

Q. Have you observed such an adequate and sensitive monitoring system at Pennhurst State Hospital?

A. No, I didn't. In fact, I observed just the opposite.

In my survey of the roughly 303 times medication was ordered, even counting where trite

phrases, such as "Behavior that I have referred to above," evaluation was only attempted 29 percent of the time.

Q. Is this a significant deficiency?

A. I would say most significant deficiency.

* * *

Supreme Court, U. S.
FILED
OCT 30 1980
MICHAEL RODAK, JR., CLERK

Nos. 79-1404, 79-1408,
79-1414, 79-1415, 79-1489

IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1980

Pennhurst State School and
Hospital, et al.,

Petitioners

v.

Terri Lee Halderman, et al.

Pennsylvania Association for
Retarded Citizens, et al.

and

United States of America,

Respondents

**ON WRITS OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT**

JOINT APPENDIX
VOLUME II, A386-A537

**Petitions for Certiorari Filed March 12 and 20, 1980.
Certiorari Granted June 9, 1980.**

THE LEGAL INTELLIGENCER, 66 NORTH JUNIPER STREET, PHILA., PA. 19107 (215) 561-4050

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**Qualifications of expert witnesses were stipulated pre-trial. Curriculum vitae designated as PARC and US Exhibits, detailing education, experience, publications and other qualifications of all plaintiffs' witnesses are found in the Final Pre-Trial Order filed at R. 464, March 31, 1978.

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[3-125] **Testimony of J. A. Lowrie**

BY MS. CHRISTENSEN:

Q. Mr. Lowrie, are you employed?

A. At the present time, yes.

Q. And where are you so employed?

A. At the Pennhurst Center at Spring City.

Q. And what is your position?

[3-126] A. A Mental Retardation Aide III, which is a first level supervisory position.

* * *

[3-130] Q. In your experience is the number of aides who are actually on duty on these wards a sufficient number of aides?

A. No, not at all.

Q. That is at the present time?

A. At the present time.

* * *

[3-141] Q. What happens after dinner?

A. After dinner they are brought back to the ward area and usually the aide staff will perform what is referred to as settle.

Q. Will you define that, please?

A. It means that they are taken into the bathroom areas, perhaps maybe, well, there's three toilet bowls in the bathroom area on that particular ward, so that they would be taken into the bathroom area and each of them would be given a turn to sit on the toilet; and after they are finished they would be gotten up and taken back down into the day room.

[3-142] Q. Have you ever actually observed this procedure?

A. Yes, I have.

* * *

[3-127] Q. Would you please state what your duties are generally?
A. Well, as a Mental Retardation Aide III supervisor I am responsible for making rounds at least once per shift of each of the cottages in the unit, writing disciplinary actions on the aides that are under me on the shift, keeping accurate time records on each of the aides, evaluating their performance and doing performance evaluation on them, doing monthly time schedules of each of the aides, where they will work and what their days off will be, and counseling them when necessary.

* * *

[3-128] Q. When you say children's unit, what age range are you referring to?
A. They would all be under 21.
Q. And approximately how many residents are residing now in Unit 5?
A. At the present time there's 105.
Q. Will you describe Unit 5? I guess Unit 5 is further divided into smaller subs; is that correct?
A. Yes. Unit 5 consists of six ward living areas.

* * *

[3-131] Q. . . . Is there a problem with time abuse with your direct-care staff?
A. Not a real problem. There is, I guess you have that anywhere — there is, I'd say out of the thirty people that I have that work for me in Unit 5 on the second shift, there may be about five that are what you consider time-abusers.
Q. And when you use the term "time-abusers" what is the number?

* * *

THE WITNESS: I am sorry.

I said that out of thirty people that are assigned to me on the second shift in Unit 5 there are perhaps five of them that might be considered time-abusers; and by "time-abusers" I am referring to someone who does not have time coming to them but takes off anyway, with not calling in, or continually takes a sick day in conjunction with two days off, or a holiday — definite patterns of abusing sick time.

[3-132] A. Well, not only does it throw off the ward's machine, but, for example, if you have a cottage where there's say, maybe sixteen hyperactive boys on it and they are used to having the same two or three aides working with them and for some reason somebody is abusing their time and doesn't show up, and you have to pull an aide from another unit or from another ward to work with that ward, when you throw somebody new into the situation not only do they not know, usually, how to handle the situation, but it also can affect the behavior of the children that they work with.

Q. Is there a high turnover rate among your direct-care staff?

A. Yes, there is.

Q. How high is the turnover rate, for example?

A. Oh, let me see. I would say since I began supervising, which was maybe about two years, I'd say almost the entire shift has been replaced, except for maybe four people that have been there through that period.

People are constantly coming and going. For instance, pregnancy leave of absence, people are let go because of poor time, maybe let go because of patient abuse — various reasons, transfer to another shift or to another unit.

* * *

[3-136] BY MS. CHRISTENSEN:

Q. Mr. Lowrie, in response to my question I asked would you please describe to me the physical characteristics of 11A. We can talk about where the boys are located later.

[3-137] A. O.K. C-11A, when you go into the entrance into the ward, the first room that you come in to is approximately 20 feet wide by maybe 35 feet long. It is a room that has blue and brown walls and brown tile floors and after you go through that room you make a right-hand turn and you come to a hallway which goes approximately, maybe it is 60 or 70-foot long hallway which has individual rooms on each side, and that's it.

That's what the ward looks like.

Q. Have you ever had occasion to visit this ward at or near the beginning of the second shift?

A. Yes, I have.

Q. And what time would that be?

A. Well, the shift starts at three, but by the time I am finished what I have to do, getting the wards and units covered, I could never really get to the ward until perhaps maybe 4 or 4:30.

Q. Could you describe for me from your own knowledge what the residents are doing at that time?

A. O.K. From the time they get back from school, which is approximately 2:30, they come on to the ward and there is a mat — the room that I described that you walk into first, which would be what I guess you would call a day room — there is a mat on the floor and there is large foam-filled play-therapy equipment that is called a doughnut.

Usually the boys are sitting on the floor. There is only one mat, so maybe three of the boys could fit on

[3-138] the mat. The rest of them would have to sit on the floor.

There's a couple of molded plastic chairs that they could sit on and they usually sit in that room and wait until it is time to take them to the dining room to eat.

Q. How is it that you know that they are sitting there from 2:30 until time for dinner?

A. There have been times — as I say, it is not regular routine that I would be on the ward very early, but there have been times when I have been there maybe a quarter after three or 3:30. I have been on the ward at different times from 3 to 11:30 and that's what they usually are doing.

If the weather is very nice and we happen to be lucky enough to have three people on the cottage a couple of the boys might be outside for a walk to get some air, but usually they are on the cottage until dinner time.

Q. And only a couple of the thirteen or fourteen residents?

A. Yes, because some of them are just too hyperactive. If you took the whole group out and you just had two staff members with them, there is a very good likelihood that one or two of them may run away.

Q. Would that be due to the insufficient number of aides to properly supervise them?

A. Yes, yes.

THE COURT: Let me interrupt you.

BY THE COURT:

[3-139] Q. Did I understand you to say that they would have returned from school at about 2:30?

A. About 2:30 is when they arrive back.

Q. Do you know where they go to school?

A. At the Liberty Forge School in Phoenixville.

Q. What type of school is that?

A. It is an intermediate school.

Q. And what type of supervision, if you know, do they receive at that school?
A. I visited the school several times with the unit director and they have a classroom in the school. They have eight or nine children in it, a teacher, and perhaps two teacher-aides; and the entire time that they are in school is just structured periods where they actually are being taught something or play therapy.
Q. When you say it is an intermediate school, who makes up the pupils at that school? Are they all from Pennhurst?
A. They are not all from Pennhurst. There are some retarded children from the community.
Q. This is a special school in that respect?
A. Yes, sir. It is not in the mainstream of the public school. It is a special school for us, for the retarded children.
Q. The thing that gave rise to my question was that you said when they returned from school, generally speaking, only two of them could go outside —
A. Yes.
[3-140] Q. — because of the few attendants and I was just wondering why, if they had been in school with a few attendants they couldn't all go outside with the attendants.
A. Usually, I say the classroom may consist of eight or nine children who probably like very much to go to school because they are getting out of the institution, they are getting a nice bus ride to school, they are sitting in a nice bright classroom, they have people working with them who enjoy working with them and are doing good constructive things with them, and it is a reinforcing situation for them.

When they know they have to ride back to the institution on a bus and get off and go into a drab ward where there is nothing provided to stimulate

them, this, I feel, really affects their behavior once they return to the ward.

* * *

[3-141] Q. At approximately what time do these boys dine?
A. At approximately 5:30 they are taken to the dining room.
Q. Do these boys all feed themselves?
A. Yes, they do.
Q. What happens after dinner?
A. After dinner they are brought back to the ward area and usually the aide staff will perform what is referred to as a settle.
Q. Will you define that, please?
A. It means that they are taken into the bathroom areas, perhaps maybe, well, there's three toilet bowls in the bathroom area on that particular ward, so that they would be taken into the bathroom area and each of them would be given a turn to sit on the toilet; and after they are finished they would be gotten up and taken back down into the day room.

[3-142] Q. Have you ever actually observed this procedure?
A. Yes, I have.
Q. Do the boys use toilet tissue?
A. No, they don't.
Q. Are they taught to wash their hands after using the bathroom?
A. No.
Q. Are there any programs being implemented on the wards to teach these self-help skills?
A. We have tried many times to develop self-help skill programs such as washing the face and hands.
Q. Are there any programs being used right now?
A. Not right now, no.
Q. Have you had occasion to observe the routine of the residents after dinner and after the —
A. Yes, I have.

Q. And what is that routine?
A. Usually they are just on the ward again, milling around or sitting on the mat on the floor, or perhaps one or two would be in the room with the T.V. set until bathing time, and then they would be showered, given their medication at 8 P.M., and then usually put to bed right after that.
Q. And that's it?
A. Yes.
Q. Were the residents in what is now C-11A always located in that particular ward?
[3-143] A. No. C-11A are the boys that were on what was referred to as Ward C-13.
Q. Could you briefly described why there were moved?
A. Well, C-13 was like a dungeon area. It was in the basement of the building. There were no windows where they could see any kind of daylight outside.

There were a few little windows around the top part of the walls, but they were only about perhaps a foot or a foot and a half wide and they were blocked off by a brick wall that was built for some new construction; so once the boys returned to that ward after school they didn't see daylight again until the next morning when they would go to school.

There was absolutely nothing on that ward that would be considered any kind of play equipment at all.

There were a lot of pipes that were hanging from the ceilings that I guess had water and electric wires in some of them, and there was wooden partitions built to separate the two bedroom areas from the day room.

It was just completely detrimental to the health of the children and provided no kind of stimulation for them whatsoever.
Q. How long were the boys left on Ward C-13 in that location?

A. Since some time in 1973.
Q. Moving next to Ward 25, have you had occasion to visit this ward on your rounds?
[3-144] A. Yes, I have.
Q. And is this the ward where there are at least two groups of children?
A. Yes. Ward 25, as I said earlier, has 32 residents living in the area.

There's approximately ten or eleven that are cerebral-palsy children and they are very high-functioning children. You can hold a conversation and they understand and they can let you know their needs.

The remainder of the children on that ward are small — smaller children than we have — males and females.
Q. Do you know a reason that these two groups of children are combined on that same ward?
A. If there is a reason, I have no idea what it is.
Q. Are there any particular problems combining those two types of residents?
A. Yes. We just moved into Ward 25 perhaps maybe eight months ago. Prior to that we were in D-1 and it was the same thing there.

They were mixed together. The bright cerebral-palsy residents had asked for a meeting with Dr. Youngberg and Dr. Meyers because they were upset about the fact that smaller children were either climbing all over their wheelchairs or throwing things at them or trying to knock them out of their chairs and they asked for a meeting to request their own separate dining areas.

There's problems having small hyperactive
[3-145] children in with people that are confined to a wheelchair. It is definitely a hazard.
Q. But they are still combined?
A. Yes, they are.

Q. Will you describe briefly what Ward 25 looks like?

A. Ward 25 is the hospital building of the institution. When you go into the entrance to the ward it is approximately forty or fifty feet wide. There would be like a hall area that you walk all the way through the entire ward, which is approximately the length of this room.

When you first go into this door there is a small room on your right. It is, I would say, maybe fifteen or twenty feet wide and about fifteen feet long.

In that room there is a mat on the floor and a couple of molded plastic chairs and in that room the smallest children on the ward are usually confined in that room from the time they get back from school until it is time for supper and then back into the room again until it is time for bathing and then put to bed.

Then beyond that room there is a small bedroom area that has six beds in it and a wall that comes up, perhaps, maybe five, four and a half feet high; and on the other side of the wall there's six more beds.

Then in the middle of the ward area is an office with windows on both sides; then two more bed-
[3-146] room areas, and then a small room at the other and similar to the room that the small children are confined to, and that small room at the other end is where the wheelchair residents usually watch T.V.

Q. Are there walls between the beds?

A. Not between the beds. There's like three beds here and then three beds with their feet facing each other and then small walls at the end.

Q. Approximately how much space is between each bed?

A. Approximately three feet, two and a half.

Q. There is no provision for privacy for that bedroom?

A. No, there is not.
Q. Is there a play area outdoors for the children who could utilize a play area?
A. There is a playground. If you go out the rear exit of that ward it has steps that go down into a playground area that has monkey bars, swings, sliding board.

But we have never been able to use it because, due to the fact that we have wheelchair residents on the ward, we felt that it was a hazard with only having the one entrance where we could come in and out of, and the far entrance has the steps that go down into the playground area.

We felt that in case of a fire there should be a ramp built at that back door so that we would have two ways of exiting from the ward area. It took quite a while before we got any kind of moving on that.

[3-147] Q. Is there a ramp there now?
A. No. There is a hole there, a large hole.
Q. Consequently, can the children get into that play area?
A. No, they would be falling into a hole if they tried to go out that door.
Q. Can they get to it any other way?
A. No. Three of the sides are closed off by buildings and the other side is a fence.
Q. Have you had occasion to observe the routine of the residents on this ward?
A. Yes.
Q. And is it essentially the same as the routine on Ward C-11A that you have described?
A. Yes, it is.

* * *

[4-179] BY MR. FERLEGER:

Q. Mr. Lowrie, I show you a document which has been marked Plaintiffs' Exhibit Number 56. This is

a six-page document entitled "Report on Present Conditions of Existing Seclusion Rooms at Pennhurst State School and Hospital," and I ask you if you recognize that document.
A. Yes, I do. I was looking for a date on the document.
Q. The document is dated January 8, 1975.
A. That's correct.
Q. At that time were you a member of the Behavior Modification Committee at Pennhurst?
A. Yes.
Q. And is it correct, as that document indicates, that you were appointed to head a subcommittee to investigate the conditions in the seclusion rooms?
A. That's correct.
Q. Would you please refer to the document, if necessary, sir, to refresh your recollection to answer these questions?

For that subcommittee, who made the tour and physical inspection of the seclusion rooms?
[4-180] A. I made the tour along with one of the other members on the committee.
Q. And did you go to every seclusion room at Pennhurst?
A. We went to every seclusion room that we were told was there, that existed at that time, yes.
Q. And what was the purpose of that inspection?
A. Well, there were several purposes.

We wanted, first of all, to see if the seclusion rooms that were in existence were adequate or — to make sure that there weren't anything in there that a resident who would be out in there alone and unattended might injure himself with; that there are sanitary conditions.
Q. Did you make a general physically inspection for any dangerous conditions?
A. Right, yes, yes.

Q. And were there any other purposes of that subcommittee's work?
A. We hoped that perhaps we could eliminate some of the seclusion rooms and if, in fact, some of them were necessary to keep, that they be brought up to some kind of standards and also the use of them be followed according to the standards.
Q. And is it correct that the last page of that document indicates that copies of your report went to Drs. Youngberg and Smilovitz?
A. That's correct; and the Safety Committee.
[4-181] Q. Now going unit by unit I would like you to describe what conditions you saw with your own eyes in those seclusion rooms.

Were there any seclusion rooms in Unit 1?
A. Unit 1 had no seclusion rooms at that time.
Q. Were there any seclusion rooms in Unit 2?
A. Yes.
Q. Describe those seclusion rooms and any dangerous or improper conditions you found there.
A. Okay.

In Unit 2 there was one seclusion room which was located off of Ward D-4. This seclusion room was also shared by the residents who were in Unit 6 or D-2, since they were in the same building.

The size of the room was approximately eight foot by ten foot. There was a screen on the door, which fits in a hole about that big with a screen on it, and the screen had sharp edges.

* * *

[4-183] Q. Will you speak about the seclusion room that you just started to describe?
A. May I read them?
Q. You may if you can first of your own recollection, as it may be refreshed by that document you have in front of you.

A. Okay. The screen that was on the window in the door did have sharp edges.

There was a radiator-cover that had sharp edges.

There was molding that was loose and sharp that could have possibly been torn off the wall and been used either as a self-abusive type of a tool or something like that.

This particular room also was on the second floor and there was a window in it and on occasion that window would be open, which also could have presented the possibility of the client being locked in that room alone and unattended and somehow breaking through that screen and jumping out the window to the cement below, which was a parking lot.

Q. What do you mean by open window?

A. The window would be open. There would be a screen on it, but actually the window itself would be open for ventilation.

Q. The only thing between the outside world and the cement ground and the seclusion room would be a typical window screen?

A. Yes.

Q. Not a security sort of thing?

[4-184] A. I really can't recall exactly what type of screen it was. All I know is it was a screen.

Q. Any other seclusion rooms in Unit 2?

A. No.

Q. Were there any seclusion rooms in Unit 3?

A. No.

Q. Were there any seclusion rooms in Unit 4?

A. No.

Q. How about Unit 5?

A. Okay. Unit 5 had a seclusion room that was right off of Ward D-3. That was located directly underneath the one that I have just described because that was on the upstairs.

Q. Any dangerous conditions you found there on your inspection?
A. Pretty much the same thing, like a lot of sharp edges on things that could have been used for self-abusive purposes.

That particular room also, as I recall, had a radiator in it which at times was hot.
Q. Mr. Lowrie, may I interrupt your description for a moment?

How long before the tour you took was the last inspection by Pennhurst officials or staff of all the seclusion rooms?
A. As far as I know, there was none.

* * *

[4-185] Q. Are there any other seclusion rooms in Unit 5?
[4-186[A. At the present time or then?
Q. As of the time of your inspection?
A. Okay. There was one seclusion on Ward 15, which was a wooden-paneled room that was in the area between the day room and the ward office area.

The problems that I recall that we saw in that seclusion room at the time — it was a wooden partition that had maybe a foot of opening at the top and maybe a foot of opening at the bottom; and also a window that was cut into the wood partition and it was big enough for somebody to stick their head through, and that was all.

We were concerned at the time that perhaps somebody could be in the seclusion and stick their head in the opening and not get it out, or also climb beneath the opening and not get out.

There was also a piece of electrical wiring that ran across the wall there that eventually led to a socket that could have been ripped loose from the wall, probably causing somebody to get a shock.
Q. The socket was inside or outside?

A. The socket was outside, but the wire that had the metal closure around it ran through the inside of the seclusion room.

Q. Any other seclusion rooms in that unit?

A. There was a seclusion room on M-3, and this was actually just another one of these rooms that
[4-187] may have been used as a bedroom but it wasn't. It was a seclusion room.

It had a heavy wooden door on it and again a hole in the door with the screen; and our concern, I recall very clearly when we were on the tour of that particular seclusion room, was that the radiator in there was extremely hot.

We found cigarette butts on the floor and a pack of matches in the closet that was in the seclusion room. The seclusion room had a closet in it and there was a pack of matches in the inside of it.

Q. Your tour was in the wintertime, I understand?

A. Yes, sir.

Q. Did you touch the radiator yourself?

A. Yes, sir.

Q. How long did you hold your hand on the radiator?

A. Not very long. Radiators in institutions, for some reason, are extremely hot. I don't know if it is the type of heat or what, but they are extremely hot.

Q. Okay.

Now the next unit. Would that be Unit 6?

A. Yes, Unit 6.

Q. Were there any seclusion rooms there?

A. There was three seclusion rooms — one in Building K-2. That was on the second floor of K Building.

Q. And K Building is now demolished?

[4-188] A. Yes, it is.

Q. Any other seclusion rooms?

A. There was one in D Building which I have already covered. That's the one that Unit 6 shared

with Unit 2 on the second floor of the D Building.
Q. Any other seclusion rooms in that building?
A. There was one seclusion room on H-2.
Q. Any dangerous conditions there?
A. Yes, there was. Again, this was a long narrow room I would say perhaps fifteen feet wide and maybe fifteen feet long and there were — again, there was electrical wires in there that were covered with metal and there was a radiator in there that didn't have any kind of protective covering on it at the time.
Q. Was this room built to be a seclusion room?
A. I imagine — well, it was made a seclusion room. It might have been a closet at one time but it was converted to be a seclusion room.
Q. Okay.

I believe we are up to Unit 7. Any seclusion rooms there?
A. In Unit 7 there four seclusion rooms, one off of Ward C-8.

I have got to really think on this because this was quite a while ago and I have to —

This was in Building — well, I could say it was
[4-189] around C-8. This again was on the second floor and it was a room that would not be situated in an area that could be very well observed, like it was a small room that was out in the hallway and then there was an office area over here and a day room over here, so it is quite — I remember discussing it with Dr. Hirst and the other people on the committee that we were concerned with the fact that somebody might have been put in that room and the aide would be in the day room or bedroom area with the remainder of the children and not be able to observe this seclusion room very carefully at that time.
Q. If you went up to the window of the seclusion room and looked in could you see every part of the room?

A. No, you could not.
Q. So the resident could be in a corner of the room where the resident wouldn't be visible?
A. Yes.
Q. Were there any other seclusion rooms in that unit?
A. In the C Building, one off of C-8, one off of C-7, another one off of C-6, and another one off of C-5.

The aide that we interviewed at the time said that the seclusion rooms off of C-5 and C-6 were not used as such. The doors were always left open and the client were allowed to go in that room and perhaps sit on the floor and be quiet, so it wasn't used, in effect, as a seclusion room.

Q. Any seclusion rooms in Unit 8?

[4-190] A. Yes. Unit 8 has a seclusion room. When you went in the front door off of the ramps or the walkway into Q-1 to your immediate right there was a seclusion room which would be the one for the boys in Q-1. I recall that very clearly because the smell in that room was unbearable.
Q. What kind of a smell?
A. From feces being smeared on the wall.

And there was also an air conditioner up high in the window, but it had been damaged quite a bit and there were sharp edges on it.

That room we were particularly concerned about from the condition of it.
Q. How high? Six feet? Five feet?
A. Sir, six and a half feet.
Q. Any other seclusion rooms?
A. The other seclusion room was on Q-2, which was on the second floor of Q Building, and that was similar to the seclusion room on C-1, very bad, smelling of feces and dirty, you know, like an animal shouldn't even be placed in a room like that. It was very bad.

Q. Did you inquire into how often the room was cleaned?
A. Well, no. I didn't, no. I don't recall.

* * *

[5-4] Q. We were talking about your survey and inspection of seclusion rooms.
A. Yes.
Q. If I recall where we were corrrectly I think you were about to describe seclusion rooms in Unit 8 —
A. Yes.
Q. — that you inspected.
A. Yes.
Q. Would you do that, please?
A. Yes.

The seclusion rooms in Unit 8, there was one located right inside the front doorway of Q-1, which was to the right-hand side after you entered the ward.

The seclusion rooms, that is, the problems we were concerned about with that particular seclusion room were that they seemed very unsanitary. There was feces smeared on the walls and the smell when you entered the room was very bad.

There was an air-conditioning unit in one of the windows that was sort of high in the air and there was an electric cord hanging down from that.

[5-5] Most of the seclusion rooms were in pretty bad disorder, like we felt that if seclusion was necessary that it should be an area that nobody could harm themselves in if they were . . . alone.
Q. Did your committee make any recommendations to the Pennhurst administration concerning seclusion?
A. Yes, we did.
Q. And what were those recommendations, and refer to your report to refresh your recollection if you need to.

A. Okay. The recommendations that we had made at the time were that it should be made clear to all the staff involved that if seclusion is necessary that it is not to be used as a punishment, but rather as a medical emergency where the person is required to be in a room alone until they have calmed down, and then should be left out.

We also recommended that a sturdy type of cabinet would be built, say right outside the door of the seclusion room, and in that should be posted the policy regarding seclusion and also the forms that would be filled out by the person who had put the person into seclusion, so that we would be guaranteed that this form would be filled out every fifteen minutes.

Q. Why was that necessary? Was there any problem with the policies at Pennhurst being followed?

A. Yes. There have been times where people were [5-6] placed in seclusion for an excessive amount of time.

Actually, as soon as a person is calmed down they should be given the opportunity to come out. We wanted to make sure that there was a guarantee that nobody would be left in seclusion for a long period of time without being monitored.

Q. Was seclusion used, did your subcommittee find, for the purposed of punishment of residents rather than for treatment?

A. Yes, it was. At times there were some clients that we had there that may have been considered delinquent-type clients and if they had gotten into some kind of trouble they would be put in seclusion for long periods of time.

There was one boy in particular who spent six days in seclusion.

Q. How long?

A. About six days.

Q. Continuous?
A. Yes.

* * *

[5-7] A. Now your recommendations went to Dr. Youngberg and Dr. Smilovitz, as you testified earlier.

[5-8] Do you know what, if any, action they took on those recommendations.
A. We never really got any kind of a reply at all as to what action was to be taken or would be taken. Our recommendations were handed in and we never heard anything about it.
Q. Were those sturdy cabinets built to post the seclusion policy?
A. No, they weren't.
Q. Mr. Lowrie, in your deposition you testified that for self-abusive residents, residents who bite themselves or hit themselves, a one-to-one therapeutic relationship is necessary to help them control their behavior.
A. Yes.
Q. Without the need for restraint or seclusion.

On what did you base that thought? On what learning or knowledge?
A. There has been numerous times — In Unit 5 we have some children that are hyperactive and we do have self-abusive behaviors.

I can think of one little boy in particular, Arthur, who has quite a bit of self-abusive behaviors, and he has some brain damage and he does become distrubed quite often.

I worked with Arthur quite a bit and I found that if I would perhaps sit him on my lap and just put my arms around the front of him and rock him for a while that would have a calming effect on him and eventually he would calm down.

[5-9] Q. And that's true of other residents —
A. Yes.
Q. — at Pennhurst also?
A. Yes, sir.
Q. And are there residents in your unit, in Unit 5, who would require such a one-to-one therapeutic relationship?
A. Yes.
Q. And are they receiving that sort of therapy in your unit?
A. No, sir.

Testimony of J.A. Flueck

* * *

[4-24] In the PARC Exhibit 48 you get a number of demo-
[4-25] graphic tables, tables that are background tables on the composition of the sample.

You see the sex, male-female, break out. You get the ethnicity, White, Black, Hispanic.

You get the age breakout, and you will notice on the age the average age of the people in the sample was roughly thirty-six years. That is the mean.

The median is also given. If you recall your high-school algebra, or if you didn't have high-school algebra your statistics in college, the median is simply that value such that fifty percent of the observations are less and fifty percent greater, so it is again another measure of the mid-point or mid-location of the assembled data.

As I understand it, this sample mean of about thirty-six years agrees fairly closely with a mean which was given by — what? The State — a day or so ago in an exhibit. I think they gave thirty-seven or something like that.

MR. GILHOOL: Your Honor, in the proposed findings of fact from the Commonwealth, they asked that the fact be found that the mean age, the average age, at Pennhurst was thirty-seven.

THE WITNESS: Table 4 gives age at entry and what you find out is that some entered very early in life and others a bit later.

The average age of entry is about fifteen years.

[4-26] Table 5 gives years at Pennhurst and what we find out is that roughly twenty-five percent of the people have been in Pennhurst ten or fewer years; twenty-five percent have been in essentially ten to twenty-one years; fifty percent have been in more than twenty-one years, and that last quartile, if you would like, twenty-five percent have been in thirty-one or more years.

You get the distribution, if you like, there on the column heading "CUMULATIVE PERCENT." You get the distribution of the number of people, if you like, or the percent of people who have been in a number of years, so on the average what you have is something like twenty-one years in residence at Pennhurst and with the indicated distribution.

Table 6 gives the most recent mental-retardation classification on the basis of IQ and so there you see the division under the five categories.

Something like around twelve percent are either mild or no MR and something like fourteen percent are moderate and so forth on up, the largest category being the profound. Roughly forty-eight percent are in the profound category.

The same classification was attempted on the basis of the adaptive behavior and there again you see the results and they are somewhat similar to the results of the IQs. They are slightly different but the proportions seem to be somewhat similar.

[4-27] Then, of course, the information on things like epilepsy, cerebral palsy, blindness, and deafness follow, and you can quickly glance at the proportions there.

As I understand it, it is not unusual to find that with mental retardation go a number of other diseases or a number of other problems, and you can begin to see that the percentages for epilepsy, for cerebral palsy, and so forth are very substantial.

Finally, we come down to mobility, Table 12, and there you find that roughly seventy-four percent are mobile and if, in fact, you add mobility, also assisted by devices, you roughly have about ninety-three percent. Only around seven percent are not ambulatory.

Table 13 gives us the dimension which we talked about earlier on communication, in other words, the presence or absence of family contact within the last three years —

Sorry, my mistake. I jumped ahead.

Table 13 is communications, how does the patient communicate; and roughly seventy-two percent use verbal measures and so forth, fifteen gestures, and twelve percent no communication.

Table 14 is the family contacts and this is the presence or absence of family contact within the last three years. Something like about fifty-seven percent had contacts and about forty-three percent had no contact.

* * *

[4-31] We are now getting to the measures of social disability or social accomplishments.

Table 21 gives you the year of the oldest Vineland.

Now remember, we started out with ninety-nine pa-
[4-32] tients in this data, this data base, and now we are going to be looking at only those patients which have both an oldest and newest, namely, two or more Vineland reports, so we are going to be looking very shortly at a change between the oldest Vineland and the newest Vineland, some measure of the change of the patient's social competancy or social disability or social functioning.

On Table 21 you simply have the distribution of the years. In other words, 2.1 percent of the patients had their oldest Vineland, namely, their first Vineland that's in the file, in the year 1940. 8.3 percent had it in 1951, and so forth on down, and 10.4 percent had their oldest in 1968 and so forth.

All right. Table 21B, which is an accompanying table, now is the measure which most of the experts feel is the best measure using the Vineland. It is a measure of the social competency or the social disability.

* * *

[4-33] Table 22 is the year of the newest Vineland, and that number is still for the subset of patients or

clients, clients or patients, who have had at least two Vinelands, the newest and the old one.

There you see the newest. You see the higher percentages toward the more recent years.

You would expect that because this is the year of the newest Vineland. All right.

Table 22B — here are your social-quotient scores based on the newest Vineland, and there you see that the data range from a score of 7 up to a score of 51, and here the data are somewhat symmetrical.

We see that the mean and the median are very similar. The mean is the value of twenty and the median also is roughly a value of twenty, so the suggestion is that this sample is pretty much symmetrical. All right.

Then let's go to a very important measure, and that's Table 23, the last table in the handout.

[4-34] This is now looking at each one of those forty-eight patients and saying let's take the difference between their newest score minus their oldest score, and that's what that column headed "Difference in Score" is.

There we see the range of differences from minus fifty points to plus ten points and there are the percentages. All right.

Well, what do we see? We can look down below and then come back. We see that on the average the patient for the period from the newest Vineland to the oldest Vineland lost about seven and a half points over his stay in Pennhurst, with a median of about 6 — six and a half points. This is a loss and if you put it on a per-year basis to the accompanying table, 23B, you get roughly around a little more than half a point loss per year per patient for each year you are in Pennhurst.

If you look at the column headed percent you will notice that we have drawn a line here at zero.

All of those scores above zero show either a loss in social quotient or no gain, so roughly around eighty-eight percent or 87.5 percent have a loss in their social quotient, a loss in their social competency; and the corresponding have a gain.

* * *

Testimony of Derek Lancaster-Gaye

* * *

[4-68] MR. GILHOOL: Your Honor, Mr. Lancaster-Gaye was qualified in a stipulation in pre-trial conference as an expert in the care and treatment of mentally-
[4-69] retarded people and in the management of residences and services for mentally-retarded and for the severely disabled people and is well versed in the history of such matters across the country.

DIRECT EXAMINATION

BY MR. GILHOOL:

Q. Mr. Lancaster-Gaye, have you visited Pennhurst?

A. Yes, indeed, I have.

Q. When?

A. On the 19th of March.

Q. And how long was your visit?

A. Between nine and ten hours, roughly.

Q. What parts of the institution did you visit?

A. It was a wide search of the hospital. I certainly visited, I find it difficult to tell you where.

Q. Did you form any impressions of Pennhurst State School and Hospital?

A. Yes, quite a number.

Q. And what were they?

A. I think I left with the unshaken feeling that Pennhurst was very much an institution like other institutions around the world.

One was left with the feeling — my visit was on a Saturday and one would expect Saturday to be quite a different day from the rest of the week and I guess one would not expect to see the usual range
[4-70] of facilities being provided on a Saturday but something in their place.

So to that extent I sensed that there was a lack of activity in the hospital.

I was struck, I think, by the poorness of the buildings themselves, which is a typical characteristic of institutions, many of which have been built, indeed, much longer than Pennhurst itself.

I was left with a feeling that the buildings — the hospital, the institutions, the whole complex — produced a sad and very real lack of stimulation for the people who lived there. It was very drab. The entire environment was such that it didn't create the sort of atmosphere which would produce stimulus.

I was struck, I think, by the fact almost evidently that there is a sense of isolation about Pennhurst. It is out in the wilds, as it were, and this is again, I think, a typical characteristic of institutions generally, and it is something that tends to rub off, indeed, on the patients.

I also left with a feeling, perhaps incorrect, because my visit was only for a short period of time, that there was almost no prospect of discharge of residents from the hospital itself, and I suppose I would base that feeling on the fact that this was an attitude conveyed to me by some of the staff to whom I spoke.

That is not to say that they said to me there is
[4-71] not much prospect of anybody getting better and going home. It wasn't that sort of thing. It was the feeling one had from talking to staff that there was a feeling of no such possibility about the future or certainly so much of the staff.

Finally, I would get that same reaction from some of the records that I saw. These records suggested that many of the patients had, in fact, been in the hospital for a very long time and one wondered to what extent there was, in fact, a chance of discharge.

Finally, I suppose having to settle on the one remaining impression I took away was a positive one rather than a negative one, your Honor, and that was that I was very struck and very impressed by the quality and the enthusiasm and, indeed, the devotion of many of the staff. This was very striking.
Q. Mr. Lancaster-Gaye, what effect do you consider that these factors — the absence of programming, the poor buildings, the lack of stimulation, the isolation, the little or no prospect of discharge — would have on the residents and staff of Pennhurst?
A. I suppose the almost inevitable analysis of problems — depersonalization is almost in everyone's words, but in my understanding I would see that as a person who is subjected to community feeding, community bathing, community toileting, and few personal relations, with nowhere to go, nowhere to go to have a cry, if you, in fact, feel that way — you
[4-72] are depersonalized and that's what I mean in that context.

So far as the isolation is concerned, one senses that the fact of isolation produces a lack of opportunity, particularly lack of opportunity to use some of the skills that one has already learned. One may well have reached the point of being relatively toilet-trained, and with inadequate toilet facilities the training is knocked out.

The opportunity to learn to speak, particularly in those with a physical disability who have problems with speaking defects; the opportunity to use what little skills you might have acquired in learning to speak are somewhat offset by the almost devastating noise that exists in any unit of that size for mentally-retarded people, more especially in wards which are cold and bare and stark as, indeed, are many of those at Pennhurst.

One wonders to what extent one has ability to use the skills of playing roles and playing games, as

it were, when, in fact, there seems in many cases to be virtually no opportunity at all to engage in a game without the role or game being completely shattered and disturbed and interrupted by violence.

I suppose in the same manner one could say that there is lack of stimulus. The present situation produced what I would regard as a series of urgencies. If you have a lack of stimulus, and this
[4-73] comes obviously from having nothing to do and nowhere to go, it is very difficult to do with nowhere to go. This quite obviously produces almost inevitably regression and that, in turn, must ultimately produce a behavior problem.

Another effect, I suppose, is the fact that the very scale of Pennhurst — and we are talking, your Honor, about 1200 patients more or less — with wards of somewhere between forty and sixty patients, with a small number of staff on many of the wards at the same time — one wonders how it is possible, and I suggest it isn't possible except in very rare instances, at rare times, for the residents on any of those wards, in fact, to relate individually to members of the staff.

What chance has a severely-handicapped person got, in effect, turning to someone who might be a powerful mother figure, someone in the figure of a transfer, somebody who will help him achieve something and go to him with the expectation of getting some sort of sympathy, and we all need sympathy sooner or later.

I felt too that there was a degree of frustation on the part of the staff because many of the residents were affected by a place like Pennhurst. It must inevitably affect the staff.

With a unit of that size there must be a large number of staff of different types and it may be that I saw only one particular type of staff with one par-
[4-74] ticular type of attitude, but certainly those I saw left

the impression that there was a degree of frustration — frustration merely feeling that so little could be done that certain programs might well have been recommended, and frustration at getting those programs put into effect with the facilities and general methods.

Certainly, I think there was frustration on the part of the staff. Indeed, on more than one occasion the word regression was used, and I also saw it written, with the thought that one of their patients, in fact, go back instead of going forward simply because of the lack of stimulus.

I think one would expect too at the end of the day, if the staff stay there long enough, and I can understand that the turnover of the staff there was surprisingly low, that there must have been in some way development of a degree of atrophy.

In fact, in my work in the United Kingdom, one tends to refer to the attitude of the staff and resident who have been there for any length of time as in happy apathy, which is a state.

Q. Mr. Lancaster-Gaye, with respect to motor disability, what did you observe at Pennhurst with respect to residents with motor disability?

A. I suppose my observations as far as they were concerned were similar, except that there was clearly a lack of understanding, I think, of the rather
[4-75] special problems of motor disability particularly with regard to cerebral-palsy patients who were there.

I saw a number of CP patients in wheelchairs without the modifications to meet some of the physical and postural problems that they would have, and I believe that other witnesses made similar reference to that.

Certainly, on more than one occasion I saw spastic young people sitting on the floor in positions

which were quite clearly to their future disadvantage.

I also had the impression that due to staff shortages it was very unlikely that the relatively large number of children, cerebral-palsy children and other spastics, must have received a relatively little amount of physical therapy, certainly less than they would normally receive were they in a community facility which is geared to provide that sort of care.

* * *

[4-80] Q. Is it then your opinion that it would be beneficial for each retarded person to live in the community?
A. Yes. I have no hesitation in saying that, and in probably three separate ways:

The community already has a very large number of retarded people living in it.

The community already has a large group of
[4-81] parents who, one way or another, are determined to go on with the problem of caring for and looking after their own children, by that time perhaps adult children, as long as it is humanly possible from their point of view.

If a parent was given some sort of choice they would in many ways be apt to go on caring for them themselves. The fact of the matter is that many are unable to do so because the local support facilities which provide the backup services — the social workers, the home help, the facility for short-term care to give Mom and Dad a break two or three times a year, to take the handicapped member of the family away during a period of domestic crisis, when perhaps another member of the family is ill — these facilities are seldom, if at all, ever available; and given that they were it would be possible for far more people to stay in the community or to go back to the community whence they came in the first place.

I suppose the second approach is still a family approach, that is, if there isn't a natural family or a part of the family that is capable of taking that retarded person, and we have the alternatives of adoption and foster care, and this is in my view deeply appropriate for adult patients or adult people as it would be for the majority of people.

Then we have, of course, the alternative of group homes, family homes. If we haven't got a [4-82] family and if we haven't got another natural family with an adoption or foster basis, okay, then you create the family home.

I think a final point I would mention here, of course, that we are all talking about actually when we talk about disabled people, about people who are disabled, to that extent the retarded person not only has the problems that retardation produces, but unhappily he has all the same problems that everybody else has because they are people; and when people tend to grow up they tend in many cases to decide that their moment has come and, in fact, they don't want to go on living with their parents and they want to move on to another sort of situation.

I would hate to think that we might be creating a situation which we perpetuated with the young person remaining at home and becoming a middle-aged person with parents who, simply because of their devotion, probably felt that they have got to go along in the absence of a suitable alternative.

Q. Why, in your opinion, is it beneficial that such retarded person live in the community?

A. Sometimes, I suppose, the answer seems so obvious that it is difficult to know where one should actually start.

It is, after all, the community that produces for us the things that we have, the life that we enjoy.

[4-83] We can't describe what it means about the community that means something to us individually. We do that regularly.

We decide when we want to dance, we decide what we are going to do or what sort of clothes we are going to wear. We decide what suit we like and what suit we don't like and it is nice to have some likes and dislikes and to be able to exercise them.

The important thing is to have the opportunity of actually saying no, I don't, or no, I won't, or I would prefer.

These are things that we tend to take for granted. The opportunity to do many things that love has to offer. This is the community, and it is a little difficult to imagine why any particular section of the community, whether they have had retarded people, disabled people, or any other sort, should not have equal opportunities to enjoy it.

So I submit, if ony for that person, the community is the right place for people to be.

But more scientifically, perhaps, and more clinically, I would have thought that the community, if, by the community we mean smaller units, if we mean units that are scaled down to the sort of facility —

THE COURT: Let me interrupt here just one second and ask you,

BY THE COURT:

[4-84] Q. What do you mean by the community?

A. By the community I mean a place where people live, where other people live, where it is all happening, where it is going on, where there are homes.

A community could well be a small village, it could well be a large one like Philadelphia.

It is merely where the people who happen to be in the area happen to live.

I don't think there is any restriction upon the size in relation to this particular argument but, as I was saying, I think it is the developmental side that is important.

I believe very thoroughly if one is to benefit, if one is retarded and one is to benefit fully from the opportunity to develop, then this happens more easily in a more stimulating way in the community and in a stimulating environment where there can be such things as individual attention, where there can be relationships and a relation between the retarded person and the people who are trained by some sort of contact and care, where there can be an improved quality of interaction between people who live together.

Q. In your opinion, is a home or a residential type house, I will say, in the community preferred to a small type institution that you have referred to of a couple hundred people?

A. Oh, yes, yes, yes.

[4-85] I mean I happen to be a person who believes that an institution is always an institution and that you can spend a lot of time and effort painting an institution and making it more comfortable, increasing the number of staff and so on and so on; and at the end of the day you have got a slightly more comfortable life if you look at that institution, and you haven't really changed the things that matter, which are the things that, in fact, enable the residents of the community to develop.

Do you see the point, sir? It is a very relevant point which I'd like to come to later on.

THE COURT: Yes.

BY MR. GILHOOL:

Q. Upon what is that opinion based, that opinion, namely, that small residences in the community

are, in the way that you have indicated, more beneficial to retarded people?

A. Well, this is, in fact, based on three things. It is based on empirical evidence, empirical studies that have been undertaken, upon the comparison of nations generally, and upon my own personal professional experience.

Q. What empirical evidence is there that the quality of life and the development of retarded people is better realized in small community residences than in institutions?

A. Really, we can push the United Kingdom again. We do have some.

[4-86] There are people who I think are quite internationally known — Jack Tizard, and Albert Kushlick. Jack Tizard, I know him very well. He is Professor of Special Education at London University.

He holds a professional chair which is funded by my organization. He is, in fact, chairman of the Retarded Educational Committee and I think he is pretty widely known in the field, and certainly in the United States as well.

Albert Kushlick is a doctor who was on the Regional Hospital Board when, in fact, it was a regional hospital board.

Q. What is it now?

A. Area Health Authority.

Q. That is to say, it provides both institutional services and community services?

A. Indeed, yes; and, indeed, the Department of Health for a long time in the United Kingdom decided to change its organizational structure in an attempt to do away with some of the boundaries that separate or the barriers, if you like, that separate some of the professional care in the field.

My organization was closely involved with the Kuchlick experiment too in the sense that we have

evolved to the degree that we paid part of the (?) and that provides a lot of these agencies.

I have some notes on these two pieces or se-
[4-88] verely-retarded children again.

Well, each unit was rated by the same observers, using a scale which at the time was known as the it had the terrifying name of the Inmate Management Scale, which is interesting because some years later, when he did his next survey, the name of the same scale had, in fact, been changed to Child Management Scale, and it had become humanized.

They have used these scales to measure the ways in which the daily lives of the residents in the institutions were, in fact, spent.

The outcome of that was that the hospitals, that is to say the institutional units, shared one pattern and the hostels another, despite the differences of the nature of the residents within the two groups; and the conclusion that was drawn from that particular piece of work was that it was the nature of the environment itself, that is to say, hospital or hostel, rather than the nature of the residents, that really accounts for the difference.

Ten years later Tizard decided that he would become a little more scientific and do the thing in an even more extensive way and he chose sixteen units as distinct from the initial six, and all of them were serving mentally-retarded people.

Five of those units were hospitals and eleven were hostels.

[4-89] Q. What are hostels?

A. Hostels are small, family-sized units in the community, relying on community facilities rather than having built-in services, with a minimum of staff, of course.

Q. What were the effective sizes of the five hospitals and the hostels?
A. Well, the hospitals varied up to about 600 patients. The hostels went down to, I think, the smallest hostel was ten residents; but within those two extremes there were quite a lot of variances, of course.
Q. What was the smallest hospital in the survey?
A. The smallest hospital, I think, was 300.
Q. And the largest hostel?
A. The largest hostel was 41.

All the children in those hostels were between the age —

No. In all the units that were part of the experiment were between the ages of five and sixteen. All had an IQ of 50 or less.

The significance of the 50 or less is that the United Kingdom's definition of retardation or severe retardation is 50 or less, so we refer to that as subnormality.

He produced a slightly amended scale of measurement which, as I say, has now changed its name to Child Management rather than Inmate Management; and again he dealt with determining the everyday life activities.

[4-90]

Now, not surprisingly, I suppose, the findings were not dissimilar. The findings were, in this case, that the hospitals produced a regimented and unstimulating result whilst the hostels produced a stimulating routine that would seem to be flexible and a lot more individual, where there was a fast-improving attraction between the residents and the staff.

The conclusion again was that it was the environment, the hostel or the hospital, rather than the residents themselves that made up the difference;

and he drew or considered as significant the fact that the better units, that it to say the units which had more flexibility, more individual care and attention, the things which one would assume would contribute to the development of the child, were, in fact, to be found in the smallest of the units.

Subsequently he complemented this with a study of five social and structural aspects of the institution and again two quite different patterns of care emerged.

One was orientation toward the residents themselves, whilst the other was oriented towards the institution; and the principal factor, he felt, that contributed to this result was assumed to be the organizational structure within the units themselves.

The size of the various units seemed to have little bearing on the results other than except that the
[4-91] best the doctor found was in the smaller areas, but this was not scientific sampling, nor did the degrees of handcaps or the nature of the handicaps appear to have any real bearing.

The view then was that an institution with 200 residents would be as institutionally-orientated as one with a thousand.

I think it is worth saying, although he didn't say it in his words, that the philosophy behind the concept of institutional orientation, child orientation, that he used, were, in fact, taken from Erving Goffman who I think is fairly well known locally, who held that management practices in hospitals, and I suspect that any of us who have worked in hospitals will not altogether disagree with this — are more in improving the organization than in trying to improve service and well-being for the residents.

An example of that philosophy quite simply is one I might suggest a conveyer approach to toileting

or bathing. If you two members or staff in a large ward and you have sixty patients to bath, this is done on a conveyer-belt principle. You take them toward the bathroom and you whip them in ten at a time.

This is directly for the convenience of the hospital because it is easier to do it, but it does do damage to the dignity of the individual.

[4-92] Unfortunately, the philosophy also tends to fall down a bit because that is not necessarily the best solution, for one member of the staff to have remained in the ward and amused the remaining fifty-eight or fifty-nine, and the other nurse might more effectively and efficiently the one child being bathed.

This is the Goffman theory as to the institutions and, certainly, the criteria that were used —

BY THE COURT:

Q. Would that be an explanation as to why they, in hospitals generally, come in and wake you up at five-thirty in the morning and say now is the time for your pill and your bath?

A. Yes, indeed.

My next comment was that inflexibility is certainly an example, and inflexibility is something which is seen when something has to happen every morning at the same time in the course of an institution, at nine-thirty every morning, because somewhere it is written that that happens.

That's the institutional approach and the same thing can be said very much of hospitals where bathing time is at a certain time, getting up is at a certain time, and where an individual would do better by either dining in the morning or having a special time for food or by doing something different than the masses, but which, to do that would create staffing problems and some other problems, and

that is quite clearly seen at the same time in the in-
[4-93] stitutions which Mr. Goffman visited.

Perhaps I could also say that happily at the time that Jack Tizard and his colleagues, Grey and King, were supported in a quite unpromoted way may be a group of people — McCormick, Balla, and Ziglar, who numbered an American, a Swede, and a Dane, I believe.

They used exactly the same scale as Tizard did in his research and they did their research in the United States and in Scandinavia and they were, in fact, really doing the same thing.

They looked at large institutions and very small ones. The very large institutions included some larger than a thousand patients, a thousand residents, and the lowest around a hundred residents. That's at one and of the scale.

At the other end of the scale they took group homes, smaller group homes that we have been discussing, where the largest group was around sixty patients and the smallest was around ten.

They too found striking differences in the care practices that were observed in each of these institutions and they discovered that the largest institutions were those characterized by the most institutionally-oriented practices and, of course, the small ones were those with the most resident-orientation care practices.

[4-94] Again, the type of institution, let us say, was a normal hospital. This was a consistent finding and in all the small hostels, again the care practices were consistently demonstrated and they came to the conclusion that their findings were precisely those of Tizard in his earlier two attempts.

Perhaps I could also briefly refer to practical operational research activities, if you like, which are very relative. First again, undertaking by Tizard,

known as the Brooklands Experiment. Here he simply removed from a hospital environment — it was a hospital in Epsom, quite a largish subnormality hospital, very much of the Pennhurst type, the sort of type that I described earlier.

They were all severely retarded and they were removed from quite clearly what was seen as an overcrowded environment and placed in a small hostel and at the same time a control group of young people were matched.

They were children who remained in the hospital and they were matched for intelligence and physical handicaps and sex and age as far as it was practicable to match children of this sort.

After a period of two years there was a comparison between the two and the results, I think, seem to be significant. It was found that the verbal scores of the children who had gone out, let us say the experimental children, had increased very significantly above those of the children who remained in the hospital and, generally speaking, those who were outside seemed to have progressed and developed more than those in the hospital.

[4-95]

The other experiment is somewhat more dramatic and somewhat more exciting. The Wessex Regional Hospital Board, as it was then part of the Government policy — decided that it would review the whole of the services of the region. Wessex is part of the south of England, and they decided they would review the whole of the services with a view to seeing to what extent additional provisions for subnormal people were needed. I say additional provisions because there is and has been a waiting list for hospital care of subnormal people in the United Kingdom for a very long time, largely on the basis that local authorities have been slow or had been at that time to develop community-based facilities.

The hospital board was to decide just what was needed, but they decided to do it in such a way that instead of discovering that they needed more beds, these beds provided in hospitals, they were doing it in such a way that the places were to be provided in the communities themselves.

They decided to set up and, indeed, did establish five hostels, again of the type that I have been talking about. These are, in the Wessex case, units of around twenty or twenty-five places.

My own organization became involved in the
[4-96] first of those with the purpose of the hospital authority. This was, in fact, a converted premises. In fact, I think two of the five were in converted premises, namely three were converted units.

All, of course, were provided or designed on the basis of a domestic atmosphere. This is an attempt to recapture a normal family feeling and the patients who went into these units were selected on the basis that they represented a realistic cross-section of ages among children, as they talked about children, or in adults, if they were adults, who would produce at least a group of people who might be expected to get on together very mildly.

These individuals had certain choices or certain opportunities to choose with whom they were going to live. What is significant is that one of those hostels, one of the adult hostels, was provided with the object expressly of taking the most profoundly-handicapped and behavior-disordered people that could be found in the local hospitals.

A second was developed on the basis that it would cater to the behavior-disordered, non-ambulant children from the hospital group; and the three adult units each took mixed groups, and what I mean by mixed groups is that they included children mildly retarded, profoundly retarded, a complete mixture.

[4-97] This was now done and after about two years there were attempts to measure the improvement that might be expected to take place, and there was ample evidence that the skills of all the patients had improved in relationship to their everyday activity, e.g., eating, table manners, washing, toileting, speech, and things like appropriate general behavior as opposed to inappropriate general behavior, and emotional response.

At least half the children in the children's hostels now go back home every weekend and they attend the hostels only five days a week. This has the obvious attraction that it enables parents and the retarded children to maintain an important link, perhaps in expectation that in time to come the children may go back and live at home permanently.

If the success of a development of this sort is measured by the number of residents who haven't made it, then I think in the first four years of the development there were three children, only three, out of something like ninety, who had to be sent home — I am sorry — sent back to the institution whence they came and for reasons which one may well argue, whether valid or not valid.

I do recollect that one of the children went back because he was a persistent biter, and biting affect was something that was more effectively dealt with, it was claimed, in the institution.

[4-98] Well, the records are interesting in the fact that they also record the fact that when he got back to the institution he went on biting. It didn't actually make any difference to him.

Three adults, I think, over a period of time were sent back to the hospitals whence they came, again for behavior disorders which were difficult to contain; and I think one honestly felt that he wanted to go back.

But that is six failures, if you like, six incorrect initial placements, which means that overall that particular scheme has been a profound success.

In answer to your question, I am sorry, it has been a long answer, those are the sort of empirical things on which one would like to base the value judgment that people are better off in the community.

BY MR. GILHOOL:

Q. In addition to the empirics of the matter you said that your opinion was based also on the effective effect of community residence and institutions on retarded people, it was based also on comparative international experience.

Will you tell us what that experience shows?

A. I have already mentioned that I have been to a number of countries and have studied the systems and I thing it is fairly general that over the past five or ten years countries, certainly in the western world and certainly those that are more advanced, have recognized the fact that community care is to
[4-99] be preferred to institutional care.

Whether those decisions on the same assumptions that we have made, whether they are based on the same criteria is of less significance, I think, and certainly most countries have produced a policy of let's get back to the community and let's stay in the community.

Some have managed to do something about it, some have not. Certainly, countries like Sweden, Denmark, the United Kingdom, the Netherlands, France, and even — not even, but Italy have managed to go some way in producing a return and certainly there are signs that hostels are springing up.

In Italy, I might say in one city, the City of Milan, they did a very brave thing. They said as of a particular date no handicapped person shall live in

an institution, no handicapped person shall go to a special school for handicapped children. Everyone from that date will go along with everyone else.

A very brave decision and the result of which one would like to have a look at in the years ahead because it does tend to presuppose that segregation is something that happens when you press a button and it comes; but nevertheless it is a way of achieving it and I think they probably get tired of waiting and said this will happen and, certainly, it has happened.

BY THE COURT:

[4-100] Q. Who made that statement in Italy?

A. Happily, in this case, the local authority in Milan made this decision, aided and abetted by all the professionals who had done their thinking about institutions.

* * *

[4-101] BY MR. GILHOOL:

Q. You said that your opinion about the respective merits of residence in the community and institutions is also based upon your own professional experience in the choice between institutional and community service.

What has that experience been?

A. Well, over the years we have engaged ourselves in a number of studies. We have undertaken or been closely involved in three studies of this precise problem.

* * *

[4-106] Lastly, the last two of those studies have now we are going to take an interest in your unit because you built it in our community.

Then we went through a difficult period, which necessarily we are always going through, in which we were acutely short of cash, and this dictated that

we should try to do something to maximize the use of the premises that we had got and it wasn't really until we started to see — it is terrible to go back — that one does these things, but it isn't until you have done them that you realize how wrong you were.

Then we tried to see to what extent it was possible to put more patients or more residents into the premises that we got in the thought that this would at least maximize the use and limit the expenses.

We never did it, fortunately, because it was during that particular period of time that we got the first of our reports that I mentioned earlier from the Institute for Research, which quite clearly came out with the normal cry, which said there is something called quality of life; and the studies have tried to perfect what that meant in practical terms and how we could, in fact, provide an improved quality of life.

And it was said to what extent can the resident themselves of the institutions that we had, because they were institutions at that time, be expected to know what was best for them. It is very dangerous
[4-107] because if you are in the situation of providing for disabled people it is very easy to fall into the trap of actually imputing to disabled people what they want without actually knowing what they want.

You merely think they ought to want it because we all like it. Although we tended to impute it to them, and we spent much time therein, nevertheless, finally, to answer your question, the end result was that if we were going to change the quality of life it seemed from the studies that we got, from the conversations that we had with residents and, indeed, with ourselves, that this meant smaller and smaller units.

So the change that has taken place over a period of twenty-four years in that sense has been the abandonment of larger units and replacement by

smaller ones and as a final stage of this we are currently going through the fairly early purposes and I hope we shall establish it as a fact early next year because we have started to build already. We are even beginning to abandon the smaller family units in place of even smaller dwellings, apartments, I guess you call them here, flats, for groups of two or four people.

Q. In your opinion, what is the optimum size of residence for severely and profoundly handicapped people?

A. In my view I think that would be around eight or ten and even that's a fairly large family.

Q. Would you then recommend as a solution to the conditions at Pennhurst the provision of such facili-

[4-108] ties in the community, alternative living places for those there?

A. Will you repeat that?

Q. Would residential facilities of that sort then be your recommendations to remedy the conditions at Pennhurst?

A. Oh, certainly, it would. Yes, it would.

Q. Why not improve Pennhurst? Why not increase staff and staff-patient ratios, reconstruct the buildings, or even divide Pennhurst into three 400-person institutions or four 300-person institutions?

A. There are two reasons, I would suggest.

The first is back to gospel. You have an institution that is, in my belief, such that there is no way in which you are going to change the end result. It is always going to be an institution, whatever you do to it.

Certainly, you can spend money on it but I would suggest it would be money very unwisely spent.

More logically, I would think the immediate answer to that question is what we all know that the

community has more to offer than an institution, so why jack up an institution if, in fact, disabled people can benefit from the community.

Q. If the choice is so clear in terms of the growth and development of retarded people and in terms of the quality of their lives, why do we continue to have institutions, and you testified we have them across the board?

[4-109] A. It is right that they are there and I suppose a large number of those institutions have been there for a hundred years or more. Those are monuments and monuments don't get torn down very quickly.

They were put there in the first place, I suggest, because the population had a fear of retardation. They didn't know what retardation was all about.

It knew that it had a commitment and felt that the commitment would be met if it built these places in the countryside.

Generally speaking, and I am sure this is true of Pennhurst as well, they are employers of people. There is, in some measure, a reluctance to destroy something that cannot be replaced.

But generally speaking there is a very substantial investment in a unit of that sort and I think an understanding reluctance to cancel one's investment in that sense.

Some countries have problems not unlike the ones we have in the United Kingdom. I haven't the slightest doubt you have your own particular version of this problem, and that's the problem of funding.

We have no one set person that pays for everything, only the members of the public.

THE COURT: I think we inherited that.

[4-110] THE WITNESS: In the U.K. the hospital service is paid for nationally. We pay for that out of our income tax, the revenue that we get from that.

The lesser authorities are responsible for a variety of community services in some manner and we pay for that as ratepayers.

Now I think it is a fact of life, because there is an enormous no-man's-land in which it is nobody's responsibility because there are claims that the recipients or the theoretical recipients could be the responsibility of the others, that one is the obligation of the other.

The fact remains that the hospitals are funded from one source and community facilities from another.

There is a difficulty, and we have experienced it ourselves, if you attempt to persuade the local authority to take out of the hospitals people who come from its area but who live in hospitals, in the knowledge that they will be a charge upon the rates. Then this is quite a different matter.

All the philosophers and the moralizing suddenly disappear because somebody has actually got to pay for them and, of course, it is very easy to refer a potential patient from the community to the hospital because it is cheaper — not because it is cheaper, in fact, but because it is cheaper for the ratepayers of the area because they don't have to pay for it.

I think those are factors which tend to perpet-
[4-111] uate the institutions.

BY MR. GILHOOL:

Q. Why do parents continue to use institutions?

A. Why not? In the majority of cases there is simply no alternative.

If you are a parent of any retarded person, if you have struggled with that person for some years, if you have got a family of your own as well, and if you get to the point where you are not going to go on any

longer and somebody says we will take your child, there is that instant feeling of relief.

You are not, in some cases, bothered where it is going to be. If a social worker leans on your shoulder and says, "Don't worry, we are going to look after Fred," you believe the social worker and the social worker may well say "Don't worry" through gratitude because she knows that the only solution at that moment in time is incarceration in an institution, and she may realize, though, that she has done it before but when that parent pays his or her first visit to that hospital they will never go back again or that they will take their child back.

Q. Is smallness by itself sufficient for the quality of life and the growth and development that you have spoken of?

A. Smallness is an awful long way but there is no way in which you are going to get the right answer if you don't plan it in advance in the right way.

[4-112]

Smallness is a vehicle which will provide the things you want, but I suggest if one is going to go small, if one is going to have hostels in the community, one has to sit down and think about it and decide how they are going to work.

One of the objects of the exercise I suggest is that we might try to achieve something we call integration. Integration is a slightly intangible thing and it could well be that we all understand something slightly different by it.

But what it is in its recognition by the community is the fact that there is somebody, some group of people who are there; and you recognize that they are there and you recognize that they have a right to be there. That's integration.

Integration also means that the people we are talking about have the opportunity to do the things that everybody else in that community has — no

privileges, no appliances, and none of the offices — just the plain chance to do the same thing, the chance to go to school like other kids, the chance to go shopping like other people. That's integration.

If you are going to attempt to get integration certainly, in this day and age and certainly, in the United Kingdom, you have to think so.

Could I mention an example, indeed, to illustrate the point?

[4-113] We were trying to persuade a local authority to do the very thing that we were discussing just now, that is, to recognize the fact that there is a large group of handicapped, retarded people in hospitals who shouldn't be there because hospitals are for sick people and these are not sick.

If they come from a particular area there is no reason why they shouldn't live in it, so how were we going to put a hostel in the community that was going to be run by the local authority who was going to accept the financial responsibility for doing it?

In such ways the children were not merely transferred from one institution to another, not less restricted, but at least an environment that was limiting because people would say oh, that's where the disabled people live; and that's not right.

In this case, it was in the seaside town of Eastbourne in Sussex. We organized with the then East Sussex County Bar, the Eastbourne-Sussex County Council, and we arranged to be provided for a site in the middle of a new housing site that was going to be built.

We talked with the architect of the entire housing site and we developed three or four — four, it was — units of six in buildings which were architecturally, externally, identical to all of the other buildings. They had their numbers in the street and they looked exactly like the others, all of

[4-114] which was acceptable.

[4-114] What happened in the back was another thing. What went on in the front was one thing; what went on in the back was another.

So it was relatively certain that the state had certain accesses and thruways which went through our property, the development, which would get people through. We arranged it so that there was a play area; the play park and things were actually immediately adjacent to the development so all the kids from the estate could at least come to this particular play area where the handicapped children were going to be anyhow.

We involved in terms of staff the people who lived on this estate, so that they make up, I think, three-quarters of the staff of the unit.

These are married persons with no particular skills, other than looking after children, looking after children of their own. Those that have young children of their own bring their children with them when they come to work and they play and the older ones go to school.

This was two years ago and two years later I think I can only say that because it was planned, because more or less all the residents came onto this site within the same limited period of time, nobody who came would turn around and say what right have they got to be there.

[4-115] It just happens that they got more people. The bus comes every morning and takes the handicapped children to school in the same bus.

BY THE COURT:

Q. Do they go to the same school?

A. I was about to say that, indeed, they go to the same school. We have arranged that all handicapped children, retarded children, go to exactly the same school as all the other children.

It might have been necessary in some cases to adapt the other facility. In the case of the school it was, but this was quite an easy way to do it and I think it is fair to say that integration is taking place.

We shall try to measure the reaction of the community after a period of a couple of years, but I don't think it is going to be necessary because they are so involved already, the result is a complete acceptance.

This is just an anecdote of what I meant really by not trying to do something in spite of everything, but getting down and trying to return people.

We do, as an organization, have a role in trying to secure the integration of people. If ever we had a particular hook on which to hang a hat, I think we would choose the integration one.

It covers so many problems, particularly with retarded people, and we are very closely involved in
[4-116] the United Kingdom in something I think you have too. It is a one-to-one organization, the object of which is to relate the members of the public to a handicapped person in the hospital, a retarded person.

In the United Kingdom ours is fortunately growing at the moment. We very recently had a television appeal in which we had a two-hour program in which we asked for 3,000 volunteers in certain parts of the United Kingdom to come into hospitals and to establish, in fact, a one-to-one relationship with a resident, where the function would be to meet them at the hospital to take them shopping, converse, talk to them, write to them, do the sort of thing that a friend would do.

Within — well, I think within two hours there were 7,000 who responded. It was very dramatic.

BY MR. GILHOOL:

Q. Does this relationship exist between people who are residents in the group homes in the community and, if so, what is their function?

A. Yes, they do exist and their function really is twofold because the function is a useful function.

People need to have access to the community and it may well be that the more retarded you are the more personal help at that sort of level you are going to need, particularly during the period of getting used to the community, so it has a very practical value.

[4-117] Also, there is a useful built-in value, that is a safeguarding factor. Whoever has the responsibility of running the organization, who are all volunteers at the moment, you can very quickly tell from the moment if he is going to blow his top. You know that something is going wrong inside and that's another useful reason for having him.

MR. GILHOOL: Thank you, Mr. Lancaster-Gaye.

I have no further questions.

[5-91] **Testimony of F. Girardeau**

* * *

Q. In your opinion is the environment, staffing level, and level of program such that each resident has reasonable opportunity to be habilitated?
A. They do not have a reasonable opportunity to be habilitated at Pennhurst.
Q. In your professional opinion does Pennhurst provide each of its residents with a minimally-acceptable program of habilitative care and treatment?
A. No. It definitely does not.
Q. Indeed, is it more likely an environment where people will lose skills?
A. Yes. In institutions like Pennhurst it is not only that you don't develop, it is that you get regression of skills.

People come in with difficulty with language systems, speech. As a function of having to keep the noise level down in large wards you don't talk for years, you don't have interaction with results, so your speech regresses.

Furthermore, one of the worst things about the large institutions, understaffed, is that you seek maladaptive behaviors, that is, you seek self-abuse, you teach people to abuse others, you teach severe aggression, so it is not only that you don't develop, you regress and then you learn maladaptive behavior.

So it is not just not developing, it is that you are
[5-92] getting worse, you are learning to abuse yourself, to pick at yourself. There is nothing else to do there so you can see this in situations where you put people in crowded areas.
Q. Is it then your opinion that Pennhurst is a failure in keeping each resident free from harm and injury?

A. I don't think that Pennhurst is keeping people free from harm and injury. They are not, from my observation.

Q. Could you describe for us what it is about the total environment which you view as destructive in the end of habilitation?

A. Well, there's three major factors about the total environment that are destructive.

First is the physical environment, the physical layout, the buildings, the wards, the training areas, so to speak.

The second aspect of the environment that is destructive is the lack of adequate staff to manage and supervise, to provide basic custodial care.

The third is the lack of staff training, that is, even if you have large numbers of staff, unless they are well-trained and continually brought up-to-date on these things that are happening — new developments in the field of mental retardation — unless you have a continual training program your staff still are not going to be able to handle it.

[5-93] So it is basically three things in the environment — physical environment, lack of staff, and the lack of staff training.

* * *

[5-111] Q. In your opinion what are the consequences of the lack of habilitative programming which you described and the destructive environment which you described at Pennhurst?

A. As I said earlier, the consequences of this are either no improvement in development or growth, either staying where you are or regressing.

The third consequence is you learn and engage
[5-112] in maladaptive behavior. You learn it and you have plenty of time to do it because there is nothing else to do.

Q. Will you describe for us what you mean by maladaptive behavior?
A. By maladaptive behavior I am referring to self-abuse — fires set, self abuse, in which people bite themselves, pull their own hair, pick at sores, head-banging. This would be self-abuse.

And then another form of maladaptive behavior is the stereotyped behavior — sitting and rocking all day long or going like this all day long, just stereotyped behavior.

Another type of maladaptive behavior is severe aggression against other people. Either ward mates or staff.

Those are the three big areas, the three most frequent areas for maladaptive behavior.
Q. In your experience under what conditions do these behaviors typically arise?
A. Well, you get maladaptive behavior arising primarily when there are four factors present in the environment.

The first factor is overcrowding. The second factor is the lack of materials, the lack of opportunities to learn, that is, no magazines, nothing to read, no training activities.

So you have overcrowding first, a lack of materials and activities; third, when there is present aggressive behavior occurring by others or maladaptive behavior, you learn to imitate from the other people and this is a fairly common way of learning aggressive behavior — you see it occurring by others and imitate it.

[5-113]

The fourth factor is that frequently maladaptive behavior is rewarded, either by adults' attention or giving the person something; so when you have a situation where there are large numbers of people that you are trying to supervise, most times the supervisor will only pay attention if there is some maladaptive behavior, so the person who gets rewarded socially is engaging in maladaptive behavior.

When those four factors are present you will usually find you will get a great deal of self-abuse.
Q. In your opinion are those four conditions present at Pennhurst?
A. Yes, they are all four present.

* * *

Q. Now from your review of the seclusion and restraint records, U. S. Exhibits 39 and 40, were you able to ascertain the incidence or the frequency of the use of seclusion at Pennhurst?
A. Yes, the general frequency of it.
Q. And how would you describe the frequency?
A. It is fairly common. It occurs, I would say, fairly frequently.

With some individuals it is much more frequent than with others. Some people, from the records, are placed in seclusion maybe five times a month and other people are placed in seclusion almost daily. In fact, there is at least one case in which the person spends ten to eleven hours each day in seclusion.
Q. Were you able, from the review of these records, to get an idea of the duration of the time the person spends in seclusion, however frequently or infrequently they go into seclusion?
A. Yes. There were time periods of three and four hours in seclusion and, of course, there was a great range.

Sometimes a person was placed in seclusion for only fifteen minutes, but it ranged up to, in one case, eleven hours in seclusion on a single day and it was repeated the next day for ten hours and the next day for ten hours.

But generally speaking the time was about one
[5-126] hour, one to one and a half hours; but there were instances, as I said, of fifteen minutes and some of three or four hours.
Q. From these records, U. S. Exhibits 39 and 40,

were you able to ascertain the incidence or frequency of use of physical restraints.

A. Yes.

Q. And how would you describe the frequency of physical restraints?

A. The frequency was much higher than seclusion, meaning occurrence of people placed in restraints every day or every other day, and it showed, the frequency of restraints, also that great deal of variety, where some people could be restrained on maybe three or four hours out of a month and other people would be restrained almost every day, so there is a lot of range of frequency.

Q. There was a lot of range also in duration of time of physical restraints?

A. Yes, approximately the same as seclusion. Generally speaking, it would be in the neighborhood of one to five hours in the physical restraints.

Q. Could you describe generally what physical restraints are?

A. They use camisoles. I think that was described to the Court the other day.

You put the hands in a heavy cloth kind of coat, but you put it on backwards and your hands, you put them around like this and they are tied at the back.

[5-127] They use muffs, hand muffs, wrist shackles, ankle shackles, face masks, halters, and a couple of others I don't recall right now that they used.

Q. From the records were you able to ascertain the reasons physical restraints were employed at Pennhurst?

A. Yes.

Q. Can you describe for us the reasons you found for it in the records?

A. Most of them were self-abuse or abuse to others.

Other things that I noted in the records, they were used for "agitated, yelling, destructive", and then, as a I mentioned, self-abuse and abuse of others.

Q. Do these reasons lead you to believe in your opinion that restraints were being used at Pennhurst for punishment?
A. It seems that in some cases, yes.
Q. Do any of the reasons you have outlined, your opinion, constitute sufficient reason to employ physical restraints.?
A. Yes. There are, on a temporary basis, until programs are developed, people who are abusive to themselves, physically abusive to others, who will have to be restrained until they can be rehabilitated or habilitated.
Q. In your opinion, with efficacious habilitative care and treatment would the incidence of the use of physical restraints perhaps be reduced at Pennhurst?
A. With the proper programming I think it would
[5-128] drop dramatically and I think the witness testified that that was, indeed, the case.
Q. What would be your view or opinion ordinarily that such devices should not be employed?
A. They should not be employed as far as the treatment goes.

They should be employed for protection — protection for the person from self-abuse or protection for other people — but should not be considered a part of the treatment scene.

They really have been shown to decelerate or get rid of the behavior, so they should not be used for treatment, but they might be used for protection until a treatment plan was developed.
Q. Are there, therefore, potential hazards with the use of physical restraints that make the use of them potentially dangerous?
A. Yes. The hazards are that the person is frequently taken out of other activities and not engaged in constructive activity.

With restraints too we found, at least in a recent year-long study in North Carolina, that some people will, after being in restraints for many years, really engage in maladaptive behavior to get put into the restraints.

So you have a situation where you can get some adult patients, you can get some adult attention if
[5-129] you do something wrong and, indeed, get put in restraints.

They found that restraints, indeed, functioned in that manner; in other words, they were positive reinforcement for maladaptive behavior, so that's one of the dangers.

I think you have to analyze the situation in each case very carefully to make certain how the restraints are functioning. You have to do a very close analysis and see what's happening.

Q. Would that suggest that when they are employed careful monitoring procedures should be used?

A. Yes, very careful monitoring procedures.

Q. The techniques that you have described to decelerate the occurrence of maladaptive behavior leading to the necessity of seclusion — are those techniques also applied to getting rid of, if you will, the behaviors that cause the need for the physical restraints.

A. I am not sure I understand the question.

Q. You described for us a number of behavior modification techniques which you said were effective in changing maladaptive behavior.

Other ways to decelerate the behaviors in lieu of the employment of seclusion, would these techniques that you described also apply to declerating the maladaptive behaviors that create the need and cause for the use of physical restraints?

[5-130] A. Yes. The same procedures could be used to get rid of those behaviors that led to the restraints; on occasion, yes.

Q. In your opinion are those techniques effective for such use?

A. Yes.

Q. And are they commonly accepted by professionals across the nation?

A. Yes, quite commonly accepted.

[5-134]

* * *

Q. In your opinion would Pennhurst ever be able to, given again the optimal conditions, offer adequate habilitative care and treatment programs to each individual resident?

A. No. I think they could get rid of the maladaptive behaviors, but I don't think they could provide the developmental growth, the developmental training that is necessary for them to be rehabilitated.

Q. Would you explain?

A. Well, you get rid of the maladaptive behaviors and always you replace it with behaviors that are useful for living in a community.

You just have someone who is not doing anything, but you could develop treatment plans at Pennhurst, but they are still isolated from the community and if a person earns them, or, well, let's take earning — if you were to earn some money there is no place to spend it.

You might develop a scrip but it would still be different from the stores in a community.

If a person went to purchase groceries and learned to cook his own meal, they wouldn't be able
[5-135] to provide stoves for everyone to learn to cook. You would have two or three stoves for all of the adults.

Even though you might cure the maladaptive behaviors, you need the community programs to teach the normal Pennhurst behavior in the community and if you don't do this at Pennhurst, largely isolated from the community largely due to people being congregated in one place, they just don't learn well in such a situation.

It is better to have them out with normal people so they can learn from them.

Q. Is it your opinion then that Pennhurst would have difficulties and that it would be practically an impossible task of trying to provide normal life settings for retarded persons?

A I'd say it is impossible to do in that large an institutional situation.

* * *

[5-137]

BY MR. PEABODY:

Q. Are there settings which, in your opinion, can
[5-138] most appropriately be used to habilitate retarded persons?

A. Yes, there are.

Q. And are these the normalized settings you have been referring to from time to time?

A. Yes, all throughout.

Q. Have you toured various community based mental-retardation programs in various communities in Southeastern Pennsylvania?

A. Yes.

Q. Could you tell us what programs you have visited and what programs were evaluated?

A. I visited programs in Delaware County, Montgomery County, Chester County, and Philadelphia County.

Q. And when did you visit these programs and facilities?

A. March 2nd, March 3rd, March 4, 1977.

Q. And could you explain how you conducted your evaluation?

A. Yes. I toured the facilities, made observations as to the programs.

I interviewed staff and I looked at some records.

Q. Did you talk to people?

A. Yes, and I talked — yes, I talked to retarded people themselves.

Q. What is your opinion as to whether all of the programs you visited are offering an adequate program of habilitative care and treatment?

[5-139] A. I found all of those that I visited — in the programs I found all of them to be offering adequate habilittion.

Q. I believe we have neglected to list the programs and facilities which you visited.

Could you list those for us?

A. Yes. I remember most of them.

I visited the Elwyn Day Development Center in Springfield, Pennsylvania.

I visited the Keystone Learning Center in Boothwyn.

I visited the Delaware County ARC work Activity Center in Lansdowne.

I visited apartments operated by community Interaction in Drexel Hill.

I visited some apartments in Delaware County that are supervised by Elwyn Institute. Those were in Clifton Heights.

I visited the Lynch Home in Willow Grove, Pennsylvania.

I visited the motivation program that is operated out of the Montgomery County ARC in Norristown. I visited Center Square School, which is a public school in Norristown, Pennsylvnaia.

I visisted the Rivercrest Center in Mont Clare.

[5-140] I visited St. Christopher's Hospital here in Philadelphia.

I visited but did not look at the programs, but I visited with the principal at the Hill School, which is in Germantown, here in Philadelphia. That's special center for trainable retarded children.

Then I visited the apartments and discussed the program in West Chester with the Chester County Association for Retarded Citizens, and I visited come apartments there in West Chester.

Q. And this tour lasted for three days?

A. Yes, and some nights. I mean we were visiting in the evenings at some places.

Q. Why was it important to visit some programs during the evenings?

A. Because the people were at work during the day and they were back in the apartments during the evenings, so we wanted to visit when they were there.

Q. You mean the retarded citizens?

A. Yes.

Q. Did the programs available cover the necessary continuum of services necessary to meet the needs of these retarded persons?

A. Yes. They covered the whole continuum from two months old retarded infant up to older, in their fifties, sixties, seventies; all types of mental retarda-

[5-141] tion from very profound, very profound with medical problems, up through people who were mildly, just mildly retarded, so it covered all ages, all types of programs and all levels of mental retardation.

Q. Could you describe the continuum of services available?

A. Yes.

The infant motivation program in Norristown is operated in a church basement doing — Sundays it is used as a nursery school for the church. This was a program for twenty children from birth to three

years of age. The youngest one there at the time was two months of age.

They had profoundly retarded, bed cases, so to speak, that had multiple handicaps, very young.

It covered social development, language development, motor development, development of cognitive or intellectual skills.

It worked with the parents. The parents had meetings. They counseled parents, worked with the parents.

These children live in their own homes, by the way. There were eighteen of them that lived in their natural home and two that lived in a foster home, but it is a three or four-hour program a day and they live in their natural homes.

They also have a program working with parents, in which they go into the parents' homes and work with the children and show the parents the techniques of developmental growth with their children. [5-142]

That's the program for the youngest ones.

Q. Was there a continuum available for the rest of the range of ages?

A. Yes.

Q. Could you describe just more briefly the kinds of services that are necessary to fill the rest of the continuum, if you will?

A. At ages three to five they usually provide nursery school and preschool and I think in Norristown I am told that now the public schools provide this.

The ARC provides it from August through June in pre-nursery school and then they need public-school education and some counseling and work with parents during school-age years.

Following school, in the later school years, high school, eight years, there is vocational training and

once they reach eighteen or twenty-one, I don't know, I am not certain in Pennsylvania whether the public schools provide education up to eighteen or twenty-one, but once they end at the high-school level, then you need vocational training, work placement, community-living arrangements, either in apartments or in small groups, homes, or with foster families; and you need that whole continuum of services.

Q. Is it your opinion that persons with all ranges of
[5-143] mental retardation can appropriately be habilitated in the community through the use of this continuum which you have described?

A. Yes.

With severe medical problems, profoundly-handicapped, serious physical problems, you would need to have medical services already available, but I think there are probably at least five medical centers in the Philadelphia area, so even for those cases, as in Omaha, Nebraska, one small wing of the Pediatrics Department, the Pediatrics Section of the Hospital is devoted to the profoundly bedridden cases and there they have available some of the best medical care available by having it in the medical-center area.

Q. You are referring to a community hospital in that respect?

A. Yes.

* * *

BY THE COURT:

Q. You said that in your tour of the counties — Chester, Delaware, Montgomery, and Philadelphia — you had observed various types of facilities for this care and housing that you preferred for individuals.

Could you describe one that you visited that may have been treating the profoundly-retarded who had physical handicaps? For instance, as you just mentioned, I think, they may have been bedriden or close to it?

[5-144] Did you tour any such community facility like that?

A. Yes, one.

Q. Where was that?

A. That was the Lynch Home in Willow Grove. They have twenty-three profoundly-retarded, and Mr. Lynch said of the very profoundly-retarded only one would fit above the notion of profound.

He had a large hydrocephalus, heavy brain injury, and communications like that.

They have twenty-three between the ages of two years and twenty-one years.

Q. When you say the Lynch Home, do you know any more about the background of the Lynch Home?

A. Yes. He was telling us that his mother and father had been operating it over years, and that he had maybe six years and it has been going for forty years.

It is just like your house or my house, just sitting there, no designation "Lynch Home for Retarded" or anything. There is just the mailbox.

There are profound levels there as you will find anywhere.

Q. Do you have any idea what kind of a staff they have there?

A. Yes. They have a nurse on duty twenty-four hours.

Q. Three shifts?

[5-145] A. Well, three shifts, three nurses, eight-hour shifts.

They have a program director. The public school for the school-age kids that cannot go out. I think eight of the twenty-three go out to public schools in some way. They might have to be picked up and carried, but they go out to public schools.

The other fifteen, those that are school-age, the public school is now providing a teacher. The intermediate unit is providing a teacher and teacher aides to come in every day from eight to four.

Then he also has a couple of staff that he pays for. The public school provides two teachers and he is paying the other.

* * *

THE WITNESS: I think I should mention there are also profoundly, multiply-handicapped at Penn Square School in Norristown. There were eight. Two of them are not all — in my interview with the teachers I asked them, you know, should these people in an institution. They are multiply-handicapped, the children not at all trained, and here they are in a public school.

And they said — the aide teachers said there is no way that these people should be in an institution.

[5-146] We can do the habilitative training here. They can get an education. We can work with the parents and they can remain in their homes.

BY THE COURT:

Q. What was the name of that and where was that located?

A. Penn Square School in Norristown on Germantown Pike. It is a public school and they have one wing of the school devoted to the retarded and there's fifty-six children there school-age.

Only eight of the fifty-six were profoundly-retarded with multiple handicaps and only two not toilet-trained.

Q. Where did they reside, if you know?
A. In their natural homes, and some in foster homes.
Q. I see. All right.
A. They were all in homes, family arrangements, not in group homes.

I interviewed the principal and she said no problem, they come and eat with the normal kids, the regular kids, and they have physical education.

But other than that, their academic day is separate. It is a wing of the school. It is partly integrated and partly not is the situation.

BY MR. PEABODY:

Q. Dr. Girardeau, I refer you now to Photograph Numbered 92 on page forty-eight and ask you if that's an accurate representation of a scene in the Lynch Home in Willow Grove, Pennsylvania, which
[5-147] you have just described to the Judge.
A. Page forty-eight?
Q. Right, Number 92.
A. The top of the page?
Q. The top of the page.
A. Yes, that is. That's the Lynch Home in Willow Grove.
Q. Can you describe what the photograph depicts?
A. There are children there, two, with extreme hydrocephalus. There is another child on the right side lying on the floor and the young woman working with the child near the fireplace is from the intermediate unit, as a teacher, a special ed unit, who works with the profoundly-retarded, and in this case I think she is doing some motor development training.

The ones on the left and the right were unattended but they were being worked with when we went into the home and the people moved back when we were taking pictures.

Q. In your opinion is that a normalized setting?
A. Yes, to a large degree.
Q. Is this setting an appropriate one to provide these individual retarded persons with a reasonable opportunity to reach their fullest individual potential?
A. I think it is if the numbers were kept low.

I personally would not like to see places set up with twenty-three profoundly-retarded all in one house. That's too many and the problems are great with that.

[5-148] Q. You prefer to see smaller numbers?
A. Yes, but at least this environment can be used even for the profoundly-retarded in what I am saying.
Q. Can you describe at this moment, not designating by name —
A. Right.
Q. Where was it located?
A. Located on the street, like the street where you live, just a house interspersed with other houses; an older house, but you couldn't tell it.
Q. A residence?
A. It was a residence, yes.
Q. Dr. Girardeau, I now refer you to Photograph 89 on page forty-six and ask you if that is an accurate representation of the infant stimulation program you described earlier in Montgomery County?
A. Yes, it is.
Q. And this is the basement of the church?
A. Yes.
Q. Could you describe what the scene depicts?
A. It is one of the rooms. This is the lower-functioning children.

This pictures a person working with a couple of real small youngsters about, oh, about a year old,

and they are doing various physical and motor activities with them.

There were some other teachers in there during the period of time but they are not in the picture.

[5-149] Q. Is this kind of program important in your opinion to prevent institutionalization?

A. Extremely important, to start early, at birth, and to work with parents, to work with children and the community, and it is extremely important to start at birth and not wait until programs develop later.

Q. Would you describe for us in more detail why early intervention is absolutely necessary?

A. Well, without certain skills you will never develop other skills. Before you can run you have to walk.

It is just that with early language development, early social development. Early intellectual development skils later on, so you have to have these basic prerequisite skills to be able to do the other things. If you don't get them you don't get the others.

Q. Were home-bound instruction and services related or conne ted with this program in any way?

A. Yes. They were working with eighteen families who had retarded children by going into the home and working with the children and training the parents in their activities.

Q. Can you explain the kind of activities that are taught in home-bound activities?

A. They teach the parents how to socially interact with their child, how to train them, language development, how to show them pictures and get them to

[5-150] name objects.

They train the parents in how to teach the child to feed themselves, toilet training, and the whole range of child development skills.

Parents are the best teachers. I mean they are with the children all the time and if you can train

the parents to do a lot of these activities they don't have to rely on large numbers of professionals.

The parents can do it. We do it for our children, so retarded parents will do it for their children.

They have problems and it becomes burdensome to them if they don't understand how long it might take or some better techniques, so the important thing is to train the parents.

Q. Are these services also important in preserving the family as the baic unit of living?

A. I think they are because in many cases it causes great family problems. A severely-retarded child, profoundly retarded, it is a strain on the family and without some help and some counseling it creates a problem for a large number, a large percentage of families.

So it is very important to have these kinds of services to maintain the family unit.

Q. Were severe and profoundly-retarded in this program?

A. Yes, severely and profoundly-retarded, very
[5-151] young, but profoundly-retarded.

Q. Dr. Girardeau, I now refer you to Photographs Numbered 90 and 91 on page forty-seven and ask you if they are accurate representations of various scenes in the apartments which you visited on Garrett Road in Drexel Hill, Pennsylvania, in Delaware County.

A. Before I answer that let me back up to the previous question for just a moment. I just want to be clear.

The infant motivation program also has some moderately-retarded and some Downs Syndromes, so they had a range from moderate down to profound; but a large number of Downs syndrome and moderate retardation.

Q. What is the Downs Syndrome?

A. The Downs Syndrome is a chromosomal defect in which the child is born with an extra chromosome and certain physical characteristics and this gives, in addition to these physical characteristics, short stature, eyes of a certain nature, a bridge of the nose, fissured tongue, a large tongue, frequently.

These kinds of characteristics are not present in all Downs Syndromes.

It used to be called Mongolism, what used to be called Mongolism. That term has been dropped and we now use the words Downs Syndrome for Dr. Downs who first described it in history.

Most of the children, most Downs Syndrome
[5-152] people, range from sixty to sixty-five IQ down to the low twenties, so there is a very wide range, but most of them are in the middle range of mental retardation.

Q. I now refer you back to Photos 90 and 91 and ask you if they are accurate representations of scenes in the apartment you visited on Garrett Road in Drexel Hill, Pennsylvania, Delaware County.

A. Yes, they are. One of them is the living room and one a bedroom in those apartments.

Q. Are these normalized settings in your opinion?

A. Extremely normal.

Q. Can you describe the use of these facilities, the nature and function of the program?

A. There were two apartments in just a regular apartment building, a duplex.

The apartment on the lower floor was a situation in which there were three boys living with house parents and they were in the school-age range and they were going out to school.

One of them in that apartment was also blind as well as retarded.

There were in the severe category, severe mental retardation.

In the other apartment, also house parents — in both cases fairly young. Turning back, they were
[5-153] about thirty, to be perfectly honest.

THE COURT: I agree with you. I think I go a lot further than you as to what is young.

THE WITNESS: Yes, I think so.

The top four are three girls and a boy. One of them is not toilet-trained. They are severe to profound.

We can't tell yet because there is a lot of education to be done, but out of the six it was reported to me that all of the parents were considering institutionalization at the time that this program became available, these apartments were set up, and they were all engaged in activities such as going on picnics, going shopping with the parents, horseback riding at the "Y" on Saturday, or arranged by the "Y"; going through a normal life routine with the house parents.

The house parents are paid. They are salaried professional people. Some are in college, some are taking additional courses to learn about mental retardation and so on.

We have a training program in Kansas to train house parents. They end with a Master's degree in Houseparentry, so we are doing more and more towards having professionally-trained, well-trained houseparents rather than just picking up people, you know, without any experience.

That's a new advance in the past five years.

BY MR. PEABODY:

Q. Is there mental retardation in these children of various ranges?

[5-154] A. No, sir. I think all of them were classified as severely-retarded.

Q. Now I refer you to Photographs 94 and 95 and ask you if they are accurate representations of scenes that you observed in the Keystone Learning Center in Boothwyn, Pennsylvania.
Q. Yes.
Q. In Delaware County?
A. Yes, they are.
Q. Could you describe for us what the pictures are depicting?
A. Photograph 94 was a group discussion. It was an educational situation in which they were discussing — I have forgotten — some past epoch of American history or something.

There were two teachers and I think there were six young boys, aged to twelve years of age, in this particular situation.

The Keystone Learning Center has eight boys and they are retarded with emotional problems, behavioral problems.

Their IQs or their levels are not down in the severe range, but they are up in the moderate-mild in terms of mental retardation.

But getting to this program, it is especially set up for retarded with severe behavioral problems so that the school system cannot handle them. This is
[5-155] set up on the Tennessee Model developed by Dr. Hobbs right after I left Peabody, in, oh, 1963. The boys come in on Sunday afternoon and they stay until Friday afternoon and they live with their natural parents or foster parents when they come in and it is a very tightly-structured situation for the fellows who have behavioral problems as well as mental retardation, so it is a very tightly structured training program.
Q. In your opinion is there any reason why various maladaptive behaviors in mentally-retarded persons cannot be appropriately handled in a community program?

A. They can be handled best in a community program, better than in institutions.
Q. Is that because of the model and learning, copying, if you will, a concept that you have outlined?
A. That's part of it; and then, where you have a ratio of — I think there are three staff members most of the time present for aid — you have a much better teaching situation with small numbers like eight boys and three teachers.

So it is not only this modeling, but also the size of the situation, the number of people congregated in one place.
Q. And Photograph Number 95?
A. 95 is where we are eating lunch. We ate lunch with the boys.

No problems.
Q. Was this a normalized setting in your opinion?
[5-156] A. Extremely normalized.
Q. Did the residents have the knives, forks, spoons, and the appropriate utensils to eat with and to eat from?
A. Yes.
Q. I now refer you to Photograph 94. Is it an accurate representation of a bedroom that you visited in the West Chester apartments in Chester County?
A. Yes, it is.
Q. Is privacy possible in such a setting?
A. That's a good example of a person having privacy, to have their own bedroom.
Q. In your opinion is this normalization?
A. Yes. It is an apartment building in an apartment complex, a large apartment complex, and it is just one of the apartments.

In Chester County the Chester County Association for Retarded Citizens operates both a preschool and a community living program for adults.

They have twenty-nine adults, some who live in group homes and some who live in apartments.

It is sort of a progression. If you have learned normal living skills in the group home you move out to an apartment, total independent living.

And I visited two of the apartments and this is one. They are both in housing projects or in housing apartment complexes.

[5-157] Q. Developments?

A. Apartment developments, just like probably where you live in Washington or Virginia.

Q. Could you explain to us why privacy is important to a retarded person?

A. Well, I don't think it is any more important to them than it is to us, but I think I mean that's one of the basic things we value.

You can do things and not be bassled by large groups. I mean you can read or listen to the radio.

When you live on a ward with forty other people, in a great big ward, you can't lie down in the evening and listen to the radio; some forty can't.

Maybe one can but the others have to listen to whatever you have chosen on the radio, so there is no freedom of choice in the large institutions and in an apartment you have a great deal of freedom of choice.

You can wash your clothes at night in the washing machine if you want to or go to a baseball game, so it allows a great deal of freedom of choice and from that you learn how to live.

That's the basic reason that privacy in these small situations is so important.

Q. What was the level of retardation of the adults living at this particular apartment development?

[5-158] A. Moderately-retarded in the middle range. I think two out of the three that were living in that apartment had been at Pennhurst, former Pennhurst

graduates, and I don't know how long they had lived at Pennhurst — quite a number of years.

Q. And they were now successfully habilitated to the point where they were able to live —

A. Yes.

Q. — in these apartments?

A. Yes, and one is in competitive employment, that is, fighting for a job in the job world; and the other one, I think is in a workshop or work-activity center.

But they all work during the day, either in a work activity or workshop or in competitive employment and fifteen out of the twenty-nine were in competitive employment.

Fifteen of the twenty-nine in the Chester County adult program had jobs, earning their money. They all had bank accounts, every one of them.

Q. And they were being taught money skills too?

A. Yes, how to purchase things on sale and all the things that he needs to know about financial matters.

Q. Now generally in the kinds of things you have just described, the goal for all returned persons is a job in competitive employment?

A. Yes, as an adult living and working and earning your way in the world, that's the general goal.

[5-159] Q. I now refer you to Photograph 93 on page forty-eight and ask you if it is an accurate representation of the Delaware County Association for Mentally Retarded Citizens Work Activities Citizens Work Activities Center, Lansdowne, Pennsylvania?

A. It is. It is a photograph of that center.

Q. And can you describe the purpose, nature, and function of the programs?

A. Yes.

This is for older retarded between the ages of twenty-one and thirty-two. I think that was the age

range of the sixty-six people who come to this center.

It is called a Work Activities Center. They are trained. The training occuring now involves learning to come to work on time, stay at your job; and the tasks they are using are similar tasks, and I think you will see in the foreground that they are assembling Liberty Bells, I guess they are assembling, and at least this particular persor is assembling Liberty Bells and it was reported to me that they get there on time, they are anxious to work, they work hard; and as they progress out of that they are referred to other, more advanced job training and hopefully eventually to seek competitive employment.

Some of them take the bus to and from the work activities.

Q. And where is the Work Activities Center located?

[5-160] A. It is in Lansdowne, in Delaware County, I think. I am not certain of my geography. I think it is Delaware; it is Lansdowne.

Q. Is it in an industrial park or a shopping center?

A. No. It is sort of on a main street in a residential area but, oh, you know, somewhat of a thoroughfare in a residential area; just about a block or two from the downtown area downtown Lansdowne.

Q. So it is located, if you will, in the mainstream of day-to-day activities?

A. Very definitely.

Q. What was the level of retardation of the persons in this program?

A. They went from severe, not from profound but from severe to moderate.

Q. Is this the kind of normalized work setting you would recommend for adult retarded persons based upon their individual needs and abilities?

A. It would be a first step, but it would only be a first step.

It is planned to get out here into more advanced work situations, but it is a necessary component in some habilitation programs.

We have to have this availability. There is some disagreement in the profession about whether you
[5-161] have to have the Work Activities Center. You might be able to have situations where you could go straight into a workshop or competitive-employment situation; but most professionals will have the work activities center in this stage of the development of the community programs.

Q. On their way —

A. On their way to competitive employment.

Q. Did you visit the Penn Square School in Norristown?

A. Yes, and I described that a few minutes ago.

Q. Which program was that?

A. The public school that had sixty-six children in a wing of the regular public school and there were eight that were profoundly retarded with multiple handicaps; and I asked the teachers should they be placed in institutions and they unanimously said no, they are dealing with the profoundly-multiple-handicaped in the community.

Q. Dr. Girardeau, of all the residents that you saw on your tour of Pennhurst did you observe any who could not benefit, in your opinion, through the use of the kinds of services and programs we have just been discussing?

A. Did I see any that could not benefit?

Q. Could not benefit.

A. No, I did not see any that could not benefit. They could all benefit from this service.

* * *

[6-3] **Testimony of L. L. Glenn**

BY MR. PEABODY:

Q. Miss Glenn, when we recessed yesterday I was about to ask you how the principles of normalization which you have described for us could be put to use in practical terms in community programs.

A. Okay.

Since both the continuum of services that are needed by individuals and the range of alternatives is different with children than with adults, I'd like to handle them separately.

First off, with children, I think it is important, within normalization it is important, to make sure that if a child in any way possible can remain in their own home they should do so. I mean with all the fancy programs that we have we certainly
[6-4] haven't found a substitute for the natural family and only in rare instances has it been necessary to take people out if appropriate services are available to the family.

Typically, there are only three reasons that a family would have to request an out-of-home type of service, one that the child would reside elsewhere.

That is a management problem with the child, the child may be growing older and larger and have physical handicaps and the family has trouble physically manipulating the child to bathe or to move around in a home that doesn't have adaptive appliances or ramps and that type of thing.

Or there may be a behavior-management problem. The child may have some behavior problems and they may need management assistance.

The second reason might be a real problem in the family. In that case the family may need assistance to keep the child in the home for the family's sake and not be a problem to the child.

The third is that not too often the children, the neighbors in the community, really don't want

somebody that has that many problems there to make a lot of trouble.

The most common, however, is the first — the family really have difficulty in different types of management situations with the child; and, unfortunately, as service has been provided in the past,
[6-5] we have only offered parents out-of-home services. We have only offered them or even encouraged them to seek institutionalization in places like Pennhurst, in a private organization, or even in community programs.

In some cases the situation exists that only an out-of-home group home or foster placement is given as an option to parents when, in fact, in most cases the families would like to keep the kids at home if the service is provided that such maybe a part-time staff member could be given to the family for maybe when the child is home from school until when they go to bed at night, from three to eight, to help that family learn to manage the child.

Or, if it is a very young child, some assistance to the family that I think we talked about earlier, in earlier testimony, would help them learn to work with that child and continue their development along the same continuum that any child would develop; or in appliances, putting ramps in the home so the child can use adaptive equipment to be able to navigate his own environment, but could not live in that house without some kind of adaptations to the house.

Other types of services might be that the family has two other kids and it is just hard to manage for a special child with special needs and to also work with the two other kids.

Maybe the family just needs a washer and
[6-6] dryer so she doesn't have to leave every day and spend three hours at the laundromat; or another part-time staff member, so that they can manage all three kids and keep the retarded child at home.

This has been very effective and most children can stay in their own home and not have to leave. In very few cases now where those services are provided does the child have to leave his own home.

In the day-to-day services we have learned a lot, both children and adults. In the past managers running home services have always, when they have identified a child or evaluated a child and found out the child had special problems, said, "Aha, that person needs a special program;" and they'd immediately take the child and put them in a group with other children that had similar difficulties or were also, you know, creating management problems.

Then you ended up with the same phenomenon which I mentioned yesterday of the child not really learning things that other children would learn because they are in a special environment and they are not given the same opportunities as anyone else.

This happened to myself. I used to teach regular education, eighth to twelfth grade and when somebody was sent to special ed class they automatically got arts and crafts instead of the developmental materials that other people had or the opportunities that other people had. It is sort of, you know, an automatic — well, kids who come to special ed class must be slower and we will give him, you know, the lower type of opportunities and materials to work on.

[6-7]

That's got to be reversed and I think it is being reversed. We are finding that if we keep kids as much as possible in the normal setting with the special supports, if necessary, that that child will learn to grow and learn to be with other kids much more rapidly or maybe not be allowed in another situation, so you would let the child enter appropriate programs that any children would enter, even if you have to provide some extra staff support or extra programming.

We have done this quite effectively in the

agency that I ran in Nebraska, where even the most multiply-handicapped children we put in normal preschools, if they were provided out-of-home services, and then we put a staff member right there, say, with four children in preschool as against thirty to thirty-five in normal school, and we would still provide the extra training with the extra staff member there.

But the kids would interact with all the normal kids and the normal kids could interact with the handicapped children also and we found phenomenal growth, even in those children that we had in our own programs that were segregated just for handicapped.

[6-8] Once they went in to a program with non-handicapped kids, the same behavior that they had been growing only slowly on in our segregated centers, they began rapid growth.

We kept a lot of data on different indices, like words spoken, sounds said, interaction, you know, interaction with teachers, initiated self-interaction with peers, different types of social behavior, other actual clinical indices; and some of it showed that within a very short period of time a number in the first six-months period with thirty-five children, some of their behaviors increased seven times above what they were actually doing in these skills when they were in a segregated situation.

So to the degree possible the children should be allowed to progress in the same type of settings with other children all the way through school and only taken out for special types of training when that was necessary for them, and it might be along that continuum that some children should participate only in certain types of activities with non-handicapped children, such as their normal recess times, such as their normal recreation or their art time or their music time, that is not developmentally or academically demanding on them.

We also found that the normal kids love it. It is another old myth that the non-handicapped kids will not accept the handicapped kids.

[6-9] My theory on that is when you get them at preschool level or at first, second, or third-grade level, we have gotten the normal kids before their parents have prejudiced them about handicapped kids to where they are not accepted.

Some children moving along that continuum really progress well. They are accepted. It is nice to see the non-handicapped kids really accepting the handicapped kids and allowing them to participate in the communities. With adults, different types of services are obviously needed. It is not normal for an adult to remain in their natural home. And adult needs to get away from the protective environment of the home and to start learning, developing his own social friends and activities.

The most important thing with adults is to really separate out the four areas of an adult's life. There are really four areas in adult life — the residential, the domiciliary, the developmental activity, whether you are still in education or have gone into recreational-vocational training, the recreational areas, we all need to recreate; the other social areas, whether it be going to church, shopping, taking transportation.

The unfortunate thing about institutionalization is that we attempt to protect all four of these areas of a person's life when he may only need training and assistance in one or two. A person could live

[6-10] by himself, but he needs vocational training, some kind of skill training. He might be able to hold down a job to assist him living in the home, but he doesn't know how to budget, how to cook.

He doesn't even know, if he earns the money, how appropriately to budget and spend that money, or may be able to live independently and work in a sheltered workshop independently without other as-

sistance, but he may have trouble using his leisure time or learning how to do the navigation stuff like transportation, shopping in the stores, comparing the shopping in the stores, and the whole range of independent living skills.

So for each of these areas we have to look independently at these areas and not try to shelter all four because there is a problem in one of those areas, and that's what an institution does.

In the residential areas we try to have the person in a most normal setting. We would not fit him in large groups.

In fact, I found that even running a large community-based service, if you got groups of adults larger than seven or eight adults the group started to become inwardly oriented and didn't reach out and make other social contacts. They were stuck with those seven or eight people and that was almost as bad in some cases as having them in the larger groups.

[6-11] You try to have the person in a situation where he is with his peers. He doesn't necessarily need a family model any longer, but maybe a college student that is living with, say, two mentally-retarded adults, a part-time college student that only needs to be there maybe in the evening, to help over the dinnertime.

Or if he needs more structure you might have a full-time staff member that's there al the time that's living with them. Then it would progress to more and more structure depending on the needs.

He may have problems, other social problems, from individuals who get in trouble with the law; certain assistance and learning with appropriate social behavior, like many retarded people are followers and so get in trouble with the law because of that.

Others have some medical problems, although the adults who are mentally retarded today probably

don't need as much medical specialization as maybe some of the kids because, unfortunately, the services in the past for the mentally-retarded, if they are adults by now, they may not have made it through to adulthood with massive medical problems.

With vocational training a whole continuum needs to be developed all the way from prevocational, from adolescence, both work training and skill training, where you learn the same expectation is on you for coming to work on time, for the type of
[6-12] relationship you have with co-workers, and also the skill training for various type of employment.

Mentally-retarded persons can take a whole range and be capable of a whole range of performance and not just some of the menial tasks that some programs offer them right now.

The training should also be in an environment as normal as possible instead of having always segregated places where the only people working around you are also mentally-retarded and also having substantial trouble. Still, the training should be provided in normal settings also.

Industry has been very good. I have run seven or eight work stations on the floor of industry, where the actual training, even for severely-handicapped persons can be right on the floor of industry, where people have also the dignity of going to a factory to work and not a sheltered workshop for mentally-retarded or an institution, which is sometimes demeaning if it is labeled like that.

So they can provide the actual skill training and that is conducive also to the dignity of the person.

The other social activities, training provided in transportation, shopping, choices allowed in the churches they go to, and then the people moving along the continuum from more structure to less structure all the time. That doesn't mean that everybody will end up independent.

[6-13] Many people, especially after long years of institutionalization, may never become totally independent, but they certainly can reach a point where they need only minimum supervision and they can exercise any freedom that they can and take advantage of as many of the types of opportunities that are afforded all of us that they possibly can.

* * *

Q. You mentioned that you had some direct experience in running a community-based mentally-retarded agency.

What agency was that?

A. The Eastern Nebraska Community Office of Retardation.

Q. And where is it located?

A. The major central office is in Omaha, but it was a five county, very large community-based program that served Eastern Nebraska.

Q. And do you have responsibilities for community-based services in your current position?

A. In my current position, yes, all the services, both institutional and community, in the State of Massachusetts, yes.

* * *

BY MR. PEABODY:

Q. During what period were you the director of ENCOR?

A. I helped start the agency back in '69, but I was not the director then. I was the director of research and planning, which meant I helped develop all the programs, write them up, get the funding for them,

[6-18] get them going, and then go on to further development.

I became director in very early '72 or '74, excuse me.

Q. And that lasted until what time?

A. Until March of '76.

Q. Could you describe briefly for us the general philosophy of the agency?
A. The agency was totally based on the principle of normalization which I discussed yesterday, which meant that all aspects of the program were designed to not only allow the person to move along the same development continuum as everyone else, but the old programs were designed to be the same as you would find for anyone else, with a special input that we needed for the mentally-retarded children.

We would be moving people along the continuum so they could use as many of the same services as anybody else did. In other words, we wouldn't, unless we had to, have special recreation programs, but rather in doing that we would work with the YMCA, we worked with all the other agencies, the Boy Scouts, the Girl Scouts, that serve anybody and are supposed to be available to anybody in the community and get them to accept mentally-retarded persons.

It was quite a large agency. We were in about 103 different locations with individualized residential types.

[6-19] We had eighteen — nineteen group residences that now house six or eight people. We had more than sixty different types of residential that would have three or less people in it. It might be a foster-home model or a staff member living with adults.

We had a continuum of vocational training. For children we had all the pre-school children from zero to five in the ENCOR agency in Nebraska at that time and provided in-home training for parents and staff to go in and work with the parents and out-of-home training for infants.

The integrated pre-schools I talked about were created at nineteen centers with maybe four or five kids in each center who would be with groups of thirty or thirty-five non-handicapped kids, with our staff in there too.

In adolescent education programs when the schools would still exclude most behavior problems, the most medically-involved children, we would provide the service and even that we got integrated. The public schools wouldn't accept it, so we contracted with the parochial schools to use space in their buildings so they would be near other high-school-age kids.

Vocational training centers — we had five large ones, but we are moving more to work stations on the floor of industry and we had seven or eight of those in-job placements and on-the-job training
[6-20] opportunities; and a network of support services that would insure there was case management, coordinating entities, and make sure there was a continuity of service.

The recreation specialist that would work with the generic recreation people; schools that would give behavioral intervention input to the houseparents.

BY THE COURT:

Q. Are you talking about Omaha?

A. Right, and the five counties surrounding Omaha.

Q. Let me interrupt to ask you a question.

In that area in Nebraska did you have or do you have an institution that could be compared to Pennhurst? I am talking about size.

A. Yes. We had one large institution, the Beatrice State Home in Nebraska. At the time I left it was about 1100 people. It was at one time, I forget, about 1600, 1700 — no, 2300, I think, back in '69.

One of our objectives in Nebraska was — and we were very lucky, we had a governor that allowed us to do a large study of the State institutions and the needs in the community that were not being met.

Beatrice in '69, was typical of most institutions: it was large, it was overcrowded, it was profes-

sionally understaffed, it was professionally isolated, out in a rural area, and could not get the professional staff.

[6-21] So the governor allowed us to do a large study and say in what direction we should go in Nebraska — should we build three more large institutions, one in Western Nebraska, one in Omaha, and one in Central Nebraska, which was a proposal at that time? Or should we go a different direction.

So the study contained both what needed to be done to clean up the Beatrice State Home and in which direction should the State go; and we opted for the model normalization.

Really, it had not been applied on a systematic State basis and we were thought somewhat radical at that time, but it has been adopted across the country now.

We decided we wanted six regional offices, not six centers, residential units, but six regional offices and each of those regional offices would be responsible for the development of a continuum of community-based services so that no person within that region would have to leave the physical boundaries of that region for any type of service; and that one of our goals would be to eliminate the Beatrice State Home.

We set out with very reasonable time lines, reasonable goals, reasonable legislative packages that had to be passed to allow us to do that.

We did start that in '69 and we were very successful. We got the institution down from the 2300, until in '76, when I left, it was about a thousand — 1100.

[6-22] Q. You are talking about a thousand or eleven hundred residents who were retarded?

A. Who were still at the Beatrice State Home.

Q. Retarded?

A. Right.

Our agency — for example, we are the largest agency. The population base for my five counties was over a third of the State's population and fifty percent of the children had known poverty in urban areas as well as a lot of rural areas, so we had a mix of service delivery types of ways we had to look at it.

Q. Let me interrupt and ask you again.

In Nebraska you just talked about this one at Beatrice, did you call it?

A. Yes. We only have one large State facility.

Q. This is the only one in Nebraska?

A. Yes.

Q. What is the population of Nebraska or what was it approximately?

A. 1.6 million, I believe.

For example, our agency had, in '69, exactly 769 people. When I left last year we only had 286 people at the Beatrice State Home.

Q. When you say you only had 200 and some, you mean 200 and some from that five-county area?

[6-23] A. From that five-county area, right; and every regional office took that responsibility of getting the people from the region back into their region.

THE COURT: I see.

All right. You may continue.

BY MR. PEABODY:

Q. Was ENCOR accredited by any national accreditation organization?

A. Yes. The Joint Commission of Accreditation of Hospitals, for facilities for mentally-retarded.

Q. Are you able to provide all of the services in your agency in normalized settings?

A. Yes, except one. I mean we went through some learning experiences too.

When we first started taking out really severely profoundly-retarded, multiply-handicapped, medically-complex kids and adolescents, we were a little

shaky on that. I mean we were a little scared, you know, and wanted to be as protective as we could, so we started it in a wing of Douglas County Hospital, and we found out that quickly, after a couple of years, services for medically-handicapped or medically-involved children, multiply-handicapped could be had, did not need to be in a hospital setting.

We just stabilized the medical problems very rapidly or found even a foster home where the
[6-24] mother might be a nurse but doesn't want to work out of the home, you know, would rather work at home and earn money doing that, so we would be able to take even a medically-involved child.

So that one service, I'd say, of the 130 locations we were in, was not normal; it was a hospital setting.

* * *

[6-25] Q. Did the mentally retarded persons in your program move through the continuum of services which you have described?

A. Yes. In fact, they moved through a lot faster than we expected. In cases where we thought some adults would need two years in a group residence before they could move to semi-independent apartments, they usually surprised us and were ready to leave and successfully left after a year or less.

So there was quite a bit of movement through the program.

Q. Were all levels of mental retardation spread through these programs you have been describing?

A. Yes. In fact, most of them were severely-handicapped because the more mildly-handicapped or high moderately-handicapped we could move successfully with minimum amounts of support into
[6-26] regular programs, whether it be public school, vocational-training programs, they were provided; and

adult education and those kinds of services for the remaining severely-handicapped population.

Q. So in your services you were able to serve severely-handicapped, profoundly-handicapped, and medically-involved persons also?

A. And for extreme behavior problems too, yes, and people in trouble with the law.

The courts, just as an alternative, had a special program for retarded adults, adjudicated and non-adjudicated, who got in trouble with the law.

Q. Could you give us an example of how these multiply-handicapped persons were served?

A. By individual cases or by the description?

Q. Let's take a pre-delinquent person that you described.

A. For a person that was in trouble with the court, in fact, the only people that we ever, in our seven or eight years of experience, had to send back to the State home was somebody that got in trouble with the court; and the court did not at that time trust us — or not trust, but they didn't know that we would provide a secure environment so they felt it necessary to send him to the State home.

Because of that, we designed a special program and got the courts approval that he, the person, whoever, could use that as an alternative placement that was secure.

[6-27] What we did was develop the same types of residential environment, two or three persons in groups, in maybe a small house with a couple of staff members, but we made it secure by the staff members.

We didn't necessarily have to lock the doors. In fact, we didn't lock the doors and we could provide a continuous supervision through the staff.

Now we have found through some of our other programs that you don't want to group people with

similar problems together. You don't want to put people with severe behavior problems in a group together and when a kid loses his head and goes into biting, you know, that kind of phenomenon goes on, and from that learning experience we found that we should not also put people in trouble with the law together. They would sort of feed on each other with the types of problems and the types of interests that they had that might not be socially-acceptable, so we broke them down into small groups of just one or two in a regular service system with staff providing the security and the support and the training for the people, and they could attend like one of our work stations on the floor of industry.

Typically, the people that get in trouble with the law that are retarded are the more mildly-handicapped, not the more severely-handicapped physically, and they have severe emotional problems too.

The mildly-retarded know they are retarded,
[6-28] know they are lower in value and really end up with a lot of emotional problems along with that, so we put them in situations that were not demeaning to them.

Instead of having them go to vocational training with other mentally-retarded persons we would have them go to a supervised work station, assembly-line operations.

We had a wooden-shoe factory in Wauneta, Nebraska, and we did maid-training for Holiday Inn, you know, those types that are more dignified.

Then after a while, with the court's approval, we could move them into a regular residential program, typically a staff apartment that did not have to be secured most of the time.

BY THE COURT:

Q. That training for the Holiday Inn, was that just in connection with the Holiday Inns out in Ne-

braska or are you talking about nationwide?
A. No. What we did, so we would have more life experience in training, we would contact just the Holiday Inn, and we would contact the people and train people to maintain both the Holiday Inn and other local motels.

We could train as many people as we wanted at the Holiday Inn.
Q. Have you had any other experience with or do you know of the programs in Pennsylvania in connection with the Howard Johnsons that are built in
[6-29] the State parks here for the primary purpose of training?
A. No, I am not.
Q. Very well.

That's the reason I interrupted when you said Holiday Inn. There is a similar project in Pennsylvania in connection with Howard Johnson.
A. It does work very well because even the people that we had in workshops, in our vocational-training centers for several years, who sort of had plateaued, they really weren't increasing a lot in development; but once they moved on a continuum and were in a real work situation, they just soared in their capability, and especially with the dignity of being able to have a regular work environment and be with other people.

THE COURT: All right.

BY MR. PEABODY:
Q. Could you give us an example of how the daily routine of a person who was severely or profoundly-handicapped with medical problems went wrong?
A. Okay. People with, let's say children with severe medical problems continually — well, the medical problems usually were not so constant that the person could not participate in a developmental program.

If they were the type of medical problem, for example, constant upper respiratory problems,
[6-30] uncontrolled seizures, it might be that they only participate — well, they might live in this hospital unit I was talking about and only leave there for a program during the day of a period of four or five hours with a nurse being at the program area in case there were a problem.

Or it might be a problem — well, it would be a problem medically that they could start attending both a full-day program outside the unit and eventually, if possible, move to a foster-home setting or back into their own home.

Their activities recreationwise would probably be more limited than those of a non-medically-involved person, but they would get outside and participate in other activities, as long as it was not endangering the medical problem.

Those kids are very few. In fact, we found that we could stabilize medical problems very rapidly and you can get seizures under control very rapidly.

You can resolve the problems, for example, of people laying down all the time. That's why they have constant upper respiratory problems. If you are laying on your back all the time you get what is known as a pancake chest, a gradual pushing down on the chest because you are not in the right position; and that decreases your lung capacity and then you end up with constant upper-respiratory problems.

If you get a person upright into a position in a chair, where a person can navigate around and get
[6-31] the circulation going better, then you don't end up with those problems.

We have found causes in the past that certainly are correctable. We found in an area, even our area had about 550,000 people in it, that we probably

only needed four or five beds in that medical unit or a medical unit like Children's Hospital. We moved people through very rapidly and again there major management model does not have to be medical. You can just be sure the medical backup is there when needed.

Q. Was there any class of retarded persons that you were unable to serve?

A. No.

* * *

[6-32] Q. Did you have any trouble at all with the parents of children that were in the institutions returning their children to the community?

A. Yes, we did, and that was —

Q. How did you handle that?

A. In two ways.

That's understandable, when parents had no alternative they had made a decision to sever themselves from the child, and it is very hard to go through that process again. I mean I can understand the emotional problem in doing that.

[6-33] A lot of it had to be demonstration. A lot of it had to be, you know, waiting with those parents until they saw that the community programs were viable. They saw that the individuals just like their sons who came out did very well when they had a chance to see them, so part of it was a waiting game, instilling those parents.

Another part was the advocacy organization in Omaha, the Greater Omaha Association for Retarded Citizens, which had a special program and the program was called Pilot Parents.

What they did was twofold:

One, when a child was identified as their sort of child, when the parents had an experience where their son or daughter was put out of the pen, so

there was less fear about having a child belong to the family.

Second, they would participate when a family would really resist their son and daughter coming out, and especially we thought it was best for the children and we talked with the parents to try to convince them of the fact of at least giving it a try.

Q. I will put this in the form of a question:

Have you experienced a situation where a particular retarded child would move from the parents' home into, we will say, a foster home in that same community?

[6-34] A. There is a problem of parents accepting the fact that another family can do a better job with their child than they can that we get into, and it is a problem.

The way that we address that is that we didn't have a normal type foster-home program that consisted of just another family taking your child; they are professionals that we train extensively. The home provided just as much structure as maybe a group residence would provide, just as much supervision, just as much training in the home.

So the image of that being just a family and just a foster home is taken out of the situation. People saw it was another professional group and they didn't have the same feelings that they would have had.

[6-35] * * *

BY MR. PEABODY:

Q. Is it your opinion that all mentally-retarded persons can be integrated into these community settings you have described without significant problems?

A. Oh, certainly, yes.

* * *

[6-36]BY MR. PEABODY:

Q. While you were with ENCOR did your agency serve every type of person who formerly lived in an institutional setting?

A. Yes. As I mentioned, we got our population from five counties down from well over 700 to a little over 200.

Q. Did you evaluate particularly or otherwise whether these mentally-retarded persons who were formerly residents in institutional settings developed and were habilitated one way or another through the use of your services?

A. Yes. In fact, we did a formal statistical analysis
[6-37] taking a two-year time period for all the children and adults who left between '74 and '76; and when you talk about the change in the persons and in the group, you really have to look at two dimensions.

One is the movement of those individuals. Were they able to move from a more structured situation after they came out of the institution to a lesser and lesser- structured; so you would have indices of movement as a criterion.

Second was clinical development. People that came out did not walk or were not ambulatory, what stage of development did they reach and how rapidly ambulation was existent, complete mobility, mobility with adaptive appliances.

There were other clinical indices, such as speech. People that came out with no speech that were able, you know, in one year, to be speaking fourth-grade sentences and have a vocabulary of 175, and their indices of social development and even academic development.

So you have both movement and clinical indices.

Q. Could you just discuss with us generally what the studies indicate in terms of growth and development?

A. The study indicated quite a rapid progress of individuals after they left the institutional services, both on the movement and the clinical indices.

For example, for about 135 adults that left the institution, that had to be placed in the highly-structured residential situation, there was only a twenty-
[6-38] four month turnover time before an average length of time in a heavily residential structured program in a community program and that is only two years before they can move to a higher, semi-independent living setting.

On the clinical indices, that really varied with the type of index.

For example, of the seventy-seven children in that two-year period that we brought out of Beatrice State Home, I believe all but — I believe that fourteen came out with not even the ability to suck, must less chew or swallow, so they were still on liquid diets and we had to go through the process of teaching them to suck and then swallow.

You have to do that. There are so many psychic problems of feeding handicapped people. For example, if they are not taught to chew and they are kept on pureed foods, you end up with problems that cause constant constipation. Constant constipation causes seizures.

If you get rid of the constipation you have to use enemas and people get dependent on enemas and there's all kinds of dental problems, so there's all kinds of problems if you don't bring the person along if you can.

Of these fourteen children that could not even suck, after the two years I think five of them were eating independently and eating regular food independently. All but one were past the chewing stage,
[6-39] maybe eating with assistance or still being fed, but certainly past the chewing stage and on to hard food.

Other indices of language. The biggest scores in language were kids in a setting where other people talked and they just started growing in language.

Ambulation was the other big one, where almost all of the kids who had come out that were not ambulatory were ambulatory or ambulatory with assistance. They may have a position chair, which is a specially-built wheelchair, just for them so that they can navigate in their own environment.

I don't have the exact data here but the growth was tremendous.

Q. Can you give us some examples, a couple of examples of individuals who showed the kinds of changes that you have been describing?

A. Okay.

Take a young child — now, thank goodness, we didn't have a lot of young children still at Beatrice State Home because we had stopped admissions from our five-county area as of '69 and we were handling them in the community instead of having them go there.

But one child that had been admitted — I will use first names if that's all right — Jenny came out.

We went to the institution and found her down there, which she did not know she entered at age three. She had massive problems. She had
[6-40] hydrocephalus, pressure on the brain. She had spina bifida because she had nerves that were pinched through an opening in the cervical cord. She had massive urinary-tract and kidney infections.

In fact, when we went down there she was dying. What was happening was that she was diagnosed as profoundly-retarded. The institution sort of laughed at us when we said we wanted to take her out to the community.

We got her out, went through a serious of operations. We had to reshunt the hydrocephalus. They had shunted her once and it got infected once and they took it out and it did not relieve the pressure on the brain.

She went through an operation to close the gaps in the spinal cord because of the spins bifida. Because of that she was paralyzed from the waist down, but that doesn't mean that she can't become mobile.

We went through a series of minor operations to resolve the infection problem in the kidney and urinary tract. That took six, seven, or eight months before she could participate in a full day's developmental program.

At first they started right at the unit, the hospital unit that she was at. Then she enrolled, we got her a positioning chair, we got her a specially-fitted chair that she could navigate and she ran all over the unit after a while.

That had a tray, you know, in front of her, so that a lot of activity could go on with her using the upper portion of her body.

[6-41] Then she was able to enroll in the Creative Learning Center, which was one of the preschools that we used with our staff in there and she was able to participate with normal kids in the preschool program.

In six months of that program she was speaking fluently, even was beginning to walk in an A-frame, even though she was paralyzed and she was really interacting with the other kids.

Then she was able to move. She got up to normal speaking level very rapidly of a normal three-year-old, after six months in the program.

Then they began to wonder whether she was retarded at all. If she was, she was only mildly retarded.

Then, with all of the medical problems resolved other than the management problems of paralysis, which a medical person had to train somebody else to do, one of the teachers at the school, they were moved into alternative living — a foster-home type, living with another family.

When I left her own family was talking about taking her back at that point, so Jenny would probably represent quite a few children that came out with medical problems.

Mike might be another good one because he is one of the first adolescents we brought out, to give
[6-42] you an example of adolescent developmental problems.

When he came out he was not fully trained yet. He had a brace on his left leg and he had some motor problems in his left arm, so he is semi-ambulatory, not quite; no speech, and he had been labeled autistic.

You never really know what that means, autism. It can mean an overlay of emotional problems or it could mean that it is a diagnosis which is very unclear, but he didn't relate to people at all.

He came out to our first children's community residence, which housed six kids.

He also had another problem of deformity of the head that was not hydrocephalus, but some sort of a condition that only deformed part of his head, but you could take care of that with his hair style that made him look like other kids so he didn't stand out because of his hair style.

He lived in that group residence and had to stay in our developmental center, in which at that time we had quite a few segregated centers. They were centers just for retarded kids until we moved to more public-school programming in the integrated centers.

He had to stay about two years, but he rapidly gained speech. After two years he was accepted into the public schools trainable program and at that time the public schools really didn't have a remedial
[6-43] training program. They didn't really want any kids that they had any major problems with and then, only after a year in the training program, they were considering him for an educable program — reading, writing, arithmetic — so he was probably only mildly retarded even though the institution had said he was severely-retarded or lower-functional when he came out.

He was another one that they said probably would not function in the community.

I could give you many other examples of adults.

Q. Is there an example of an older person you could give us?

A. Quite a few, yes. I could pick almost any.

Well, I heard Downe syndrome mentioned in earlier testimony and there are such myths about Downe syndrome people that maybe I ought to take a Downe sydrome adult that came out.

They had institutionalized him for about twenty years and coming out into an adult group that had just eight people, in two years he was ready to move from the adult residence, which was more of a highly-structured program, to an apartment where a staff member just lived next door, that checked in on him every now and then, at least once a day.

He had joined a regular bowling league and was doing well. It was one of his favorite sports.

[6-44] He navigated the community totally. He worked at the Benson Vocational Centers, one of our vocational centers, for about a year and a half and that was while he was in the group residence.

He moved to a work-industry, I think Geiger Food Products. He was still independently living,

but still needed structure in the work setting, so he was working at Geiger for quite a while. I don't know if he has left yet, but he was quite successful.

There are many adults like that — different kinds of training periods, they need. Some may stay in the structured vocational or residential setting, but they certainly move along, needing less and less assistance on an ongoing basis, and really lead full lives.

It is amazing to watch some people come out of institutions. Some people come out and they live in an apartment and they go to their apartment and you find that they haven't decorated it and you sort of wonder why, why haven't they pictures up or other belongings.

And you try to encourage them. They don't know how to express themselves. They have been in such large congregate groups for so long they have no self-identity and self-expression.

Once they get that in one area, like we encourage people to decorate their own space or living
[6-45] space, they start getting it in all other areas.

Some people might think that people talking back to you is not good, but it is certainly self-expression. They start really making their own choices and making their own demands, as well as knowing how to make those choices in the community and to watch their developmental process.

Often a person really does not know how to be an individual because he has never been treated as an individual. It is quite amazing and it is quite rapid.

Q. Was there any mentally-retarded person in your services who did not grow or develop in any way?

A. I can think of one man. I am not sure I can say no growth, but his growth was cyclic.

We were a data-based organization and really looked daily at the developments and kept measur-

ing the data base for a unit data decision and his growth was cyclic.

You know, he would grow, build up to a level, and he had some problems and then he'd go down. It was sort of a cyclic type of growth that he had that was not too much going up for the whole period.

But that was only one young man and we had resolved some of his problems by the time that I left. We had found out that he was deaf and he had some emotional problems and he had some medical problems.

That's probably the only one I can think of.

[6-46] Q. By participation in the available services did the level of functioning of all of those participating go up or go down?

A. Oh, it went up dramatically. In fact, I'd have to say that with the services we have been able to teach the young, to provide a continuum of movement for them, a program for them. You could see the scale of mentally-retarded pushed up.

All of a sudden we never even end up with people being profoundly-retarded any more. We have sort of eliminated that in the sense that people who are profoundly-retarded are those with no communication skills and laying on their backs.

The people that came out with a diagnosis of severely-retarded were monitored retarded and the scale was pushed up for all the persons.

Q. Did you ever come in contact with a previously-institutionalized person who seemed to want or desire to return to the institution?

A. Two — the two phenomena seem to exist — the answer is yes.

Some adults did not want to leave the institution. Some adults, when they got into the community, initially wanted to go back to the institution.

I am sure this phenomenon, from what I have seen in the other states, does exist.

In the first case you have a situation where probably the external fear that a person receives
[6-47] about community living is through watching Dragnet and Gunsmoke and they are a little leery about going out into the community when what they see on TV is, you know, uncomfortable to them about walking out there.

So they have some inhibitions about the challenge and what I have specifically done is ask them — not force them, but asked them if they are willing to give it a three-month trial and come back in that time.

I think I have had only one man, mentally-retarded, seriously emotionally-disturbed, that after that trial period still wanted to go back.

The other instance is that the community does offer the service system or life that a person needs in the community is quite a bit more demanding than some institutions place on those persons and some adults reach the point of, well, I'd rather lead the lazy life in the institution where there are no demands on me, where nobody does anything relative to making me work.

Some will hit that point and then they have to make a choice. There is the dignity of being out and having freedom and the dignity of being able to earn your own living, and the question is whether it is worth that tradeoff; and most decide that it definitely is.

I have never had anybody want to go back for reasons of the challenge that it places on them, and
[6-48] the demands; but sometimes there is an initial culture shock that they go through and that has to be worked through.

Q. In your opinion can community-based services overcome this apprehension or lack of preparedness for persons who come into the community to live?

A. Yes.

Q. And was ENCOR able to overcome these kinds of apprehension?
A. Yes.
Q. Are you familiar with the community-based mental-retardation services in the Commonwealth of Pennslyvania?
A. Yes. I have done quite a bit of work with Pennsylvania since about '71 or '72, both having some people that work with me work here, so I keep pretty close contacts.

Also, I did some of the early training programs for Pennsylvania in the evaluation tool that they use for the community residential program.

So I have, I think, since '72 done three large workshops in '72 and '73. That included evaluating a lot of the programs, especially around Harrisburg, around Pittsburgh, and around Philadelphia.

And then I participated here in evaluating other programs.
Q. Have you had an opportunity recently to visit certain community-based mental-retardation programs in the five-county area surrounding Philadelphia?
[6-49] A. Yes, I have.
Q. And when did you visit?
A. March 12th and March 13th.
Q. 1977?
A. Yes.
Q. And where did you visit?
A. I visited the Montgomery County Mental Retardation Center and spent quite a bit of time with the staff of that center.

I visited the women's group residence on Mount Airy Street in town.

I visited a women's residence in Pottstown for eight women.

I visited an adolescent residence for boys, six adolescent boys, two of whom were from Pennhurst.

I visited St. Christopher's Hospital in the respite-care program that they have available for families on weekends.

I visited Horizon House at 1315 Federal Street, which was a women's residence, with several from Pennhurst.

In fact, in every program there were several that had originally lived in Pennhurst.

I visited the Intercommunity Action Program and I visited two sets of apartments they had for mentally-retarded adults, several of which were originally from Pennhurst.

[6-50] The Elwyn Institute, which runs a large apartment-training program that serves twenty-three people, some from Pennhurst.

And the Eman coeducational residence on Vernon Street that had both men and women, some from Pennhurst.

* * *

BY MR. PEABODY:

Q. Did you visit nine or ten different programs in the two-day period?

A. In this trip, yes.

Q. And how was your evaluation conducted?

A. Mainly just by staff visits, by interviews with the staff, by interviews with the residents, by a review of many of their past evaluations that had been done on the places, by discussions with other people that were familiar with the programs, and any materials that they had available that I could evaluate.

Q. What is your opinion on the level of the quality of services available?

A. I think they are excellent. I think they are very good.

[6-51] In fact, Pennsylvania has had several years, or more than that, five or six years, developing community service and it is very good and they monitor quality of that very extensively based on the same principles that we have been talking about, based on normalization.

The people in these residential programs were certainly leading a full life. They were involved in all kinds of community activities. They had access to adult basic education when they wanted it. They would decide for themselves to go at length about the type of activities, the jobs they had, the way they really interfaced with the community.

The State spent a lot of time and we talked a lot about the changes in people they had seen, especially those that came from various institutions, not just Pennhurst.

Q. Were all of these programs that you visited offering an adequate level of habilitative care and treatment?

A. Yes, definitely.

Q. In your opinion were adequate and perfectly-qualified staff available in the various programs that you visited?

A. Yes.

Q. Were the programs you visited all offered in normalized settings that you have described?

A. Yes.

MR. PEABODY: Your Honor, may I approach the witness?

[6-52] THE COURT: Yes, you may.

BY MR. PEABODY:

Q. I now direct your attention to Photograph 70 on page thirty-eight of U. S. Government Exhibit 48, and ask you if that is an accurate representation of

an external view of the apartments you visited on Parker Avenue.

A. Yes, it is.

Q. I now refer you to Photo 74 on the next page and ask you if it is an accurate representation of the exterior of the adolescent residence you visited on that unpronounceable avenue?

A. Yes, it is.

Q. I next refer you to Photograph 76, again on the next page —

THE COURT: I just want you to know that anyone that can pronounce the name of the river that flows nearby, not the Delaware, can also pronounce Wissahickon.

BY MR. PEABODY:

Q. I next refer you to Photograph Number 76 on page thirty-nine, and ask you if it is an accurate representation of the external view of the group home at 143 East Mount Airy Avenue.

A. Yes, it is.

Q. Photo 77 on the next page, is that a view of the surrounding area of that group home?

A. Yes, it is.

Q. Is this representative of the kinds of settings you found throughout your tour?

[6-53] A. The only one that was slightly different was the Elwyn Institute apartments. It was in a quite a bit more urban area, a large apartment building, where they had one floor of apartments that they did training in.

Otherwise, all of the community residential programs were in very similar neighborhoods. They were in residential areas.

BY THE COURT:

Q. Do you recall where that apartment is located, the Elwyn Institute apartments that you have just referred to?

A. Do you have the address? I probably have it.
Q. I just wondered if that was located out at the Elwyn School or in that vicinity.
A. No.

MR. GILHOOL: On Chestnut Street in West Philadelphia.

THE COURT: In Philadelphia?
Is it connected with the Elwyn School?
MR. FERLEGER: Yes, it is, your Honor.
Their apartments are at 3900 Chestnut Street.
THE COURT: Very well.
I just wanted that clarified.

BY MR. PEABODY:

Q. Is the parents' consent important in the programs?
A. Yes, it is, in every instance.

[6-54] I think yesterday I covered a lot of them, the fact that they learn how to navigate in the community and be in the community, learn how to utilize shops and recreation facilities and churches and transportation lines, to be near them, so certainly the location is important.

The ability to interact with neighbors, so that you are not in another kind of setting that you only associated with handicapped people is important.

The image of the program is also important. We have done a lot in the past harming those people by stigmatizing them. If one of these good residences has a big sign out front that said "Community Residence for Retarded People", I am sure the neighbors, like has been shown, would be much less willing to accept them as members of that community or not be slightly fearful of them, just treating them differently, again the expectation problem.

But the dehumanization of living in places where they are stigmatized or unwanted in that community or stand out, like you wouldn't want a

big fence around one of these either, the people would think this was potentially dangerous if you had to have a great big fence.

Normally, the appearance in the community is highly important.

Q. Normalizing?

A. Yes.

[6-55] Q. I now refer you to Photograph 69 on page thirty-six and ask you if it is an accurate representation of a living area or a living room in the women's residence at 500 North Franklin Street in Pottstown.

A. Yes, it is.

Q. Is Photograph 71 on the next page another living area? Is that an accurate representation of the living room in the apartment at 300 Parker Avenue?

A. Yes, it is.

Q. And Photograph Number 73 on the next page, I ask is that an accurate representation of another living area, this time in the adolescent residence on Wissahickon Avenue?

A. Yes, it is.

Q. And were these kinds of living rooms typical of those in the group residences you visited?

A. Yes. They were all quite a big beautified and very comfortable, home-like environment.

Q. Can you explain briefly why these normalized settings are important?

A. For a range of reasons, mainly — well, we discussed comfort and beauty yesterday, but really the training of selection, of choice, of self-expression.

Most, in fact all of the adult residents that we visited, you know, told us the stories of how they got decorated by the residents' participation in decorat-

[6-56] ing the living rooms, the residents being able to make choices about furniture and decor, as well as experiences of buying and shopping for those, the training experiences of keeping up your own home, so they are able to move to an apartment.

All adults participated in the actual maintenance of the house. They would rotate on both the cooking and the cleaning, so it is, you know, a real-life experience. They are involved in a real live house, not an artificial type of environment.

Q. I now refer you to Photograph 79 on page forty-one and ask you if it is an accurate representation of a bedroom in the Interac Shoreham Apartments that you visited.

A. Yes, it is.

Q. Is Photo 83 an accurate representation of the bedroom at the residence at 729 Vernon Road?

A. Yes, it is.

Q. Photo 78, is that an accurate representation of the bathroom in the Interac Shoreham Apartments?

A. Yes.

Q. Is Photograph 82 an accurate representation of a bathroom at the Vernon Road residence?

A. Yes, it is.

Q. Are these normalized settings, in your opinion?

A. Yes, they are.

Q. Is privacy possible in these settings?

[6-57] A. Very definitely.

Q. Can you describe for us how they are important in other ways?

A. Well, I started to say, you know, it was very —

Well, all the residents were so proud of their rooms and the fact that they had their own either private or at most semi-private rooms.

I think one of the proudest things that people have is their own living space, the ability to be alone if they want to, the ability to have their own possessions and not have to worry about whether or not it is going to be taken away or stolen, to have a place to keep those possessions.

The young man in Picture 83 was showing me his own TV that he had bought from income that he had from a workshop. He had places to store his

own possessions. He can start to really learn about taking care of his own things.

Involved in that whole process is teaching and training about budgeting your money, about shopping in the community, about sharing your own possessions — things that we would normally learn or normally have learned that have to be taught now.

This young man had been institutionalized for quite a while, but the pride comes through and the pride comes through very strongly.

Q. Are these representative of the bathrooms and
[6-58] bedrooms that you visited in the other various residences?

A. Yes.

Q. Again, are these normalized settings in your opinion?

A. Yes, they are definitely.

Q. Do these settings allow for freedom of movement in normal daily living?

A. Yes, they do.

And the residents talked extensively about what they did and what the whole rhythm of the day and year was like.

In fact, quite a few of the residents had taken vacations last summer to various places. California was one, Florida was another, and they would talk about these and show the possessions that they had gained while they were there.

Typical, normal life style, I guess.

Q. You talked to the residents in the various group homes?

A. Yes, I did.

Q. Did you talk to houseparents and other professional people there?

A. Yes.

Q. And were you able to ascertain whether any of these retarded persons, formerly residents at

Pennhurst, had changed, grown habilitative through the various programs available?

A. Yes. Two of the things that I was very interested in when I was talking to each of the staff of these programs was, one, the movement. You know, how
[6-59] people actually moved from that type structure to a lesser-structured situation, and much movement has occurred from those types of group residences to apartments, like the one on Parker Avenue, and more people were ready to move.

They were developing new apartments to move to.

Then the staff and the clients would talk extensively about what skills the person had gained that allowed them to be able to move from that setting to another setting of less structure.

There were many discussions about the lack of skills persons left the institutions with and how rapidly they gained the skills, whether they be in the area of cooking or sewing or clinical things like speech, different types of social adaption skills, the ability to navigate in the community.

The adolescent residence was very interesting and drew a very, very sharp contrast between the four boys that had previously lived in their own home and then came to the adolescent residence, and the two boys who had been at Pennhurst for several years and came to the community residence.

They indicated that it was a very sharp contrast with the types of problems and behaviors that the two boys from Pennhurst had, that took a long — well, it took about a year of stabilizing those behaviors to get rid of them and now they were, you know, they were fine.

They also were pretty heavily medicated when
[6-60] they came out of Pennhurst and they got them off that medication very quickly. There was quite a bit of contrast particularly in the rapid growth.

Q. Did the services that you visited represent a continuum of needed services to meet the individuals' needs?
A. They represent a continuum, yes. I think the programs that we are looking at now are even developing more steps in the continuum that they had not developed before.

They certainly were all willing to expand services to accommodate many, many more persons from Pennhurst or elsewhere. They are taking a look at staffing patterns that are going to have to be different as they serve more and more severely-handicapped persons, to prove that the same continuum will work for the more severely-handicapped.
Q. In your opinion can the services and programs you visited be expanded and still maintain the high quality which is current?
A. Yes. I talked to each of the program directors about how much, since they are non-profit agencies, how much the agencies are really looking at expansion, how much they are willing to expand, what they think it would take to assist them if they perceive any problems in expanding.

And they were certainly all willing, they were very interested people, very community-oriented in their own communities, and want to make sure that their growth is appropriate to those communities.

[6-61] But they only see a few problems and are rapidly expanding their services to meet the needs of those problems and those problems will be resolved relatively easily.

That was my conclusion from my evaluations also.
Q. In your opinion are the programs monitored closely enough to insure good-quality services?
A. Yes. In fact, the model that provides the community-living arrangements is very good for monitor-

ing. What I mean is that what it does it set up almost every community program. That community program may have five or six residences plus a day program. They may have one program.

But each of those programs has its own board of directors and typically the board of directors includes not only some professionals but parents; it includes interested citizens, so you have got a board over programs in the community that are constantly monitoring the quality of that service.

You have got a situation where — you have seen the pictures — the house the community residence is in is abutted by two other houses and the houses across the street. You really — I mean the problems that have come in large congregate settings cannot come up here. You are monitored by your neighbors, by the schoolteacher when the kid goes to school, who see if the kid is having any problem. You have got so many people monitoring the
[6-62] community programs that it is much better than any other type of setup.

In addition, Pennsylvania for several years in these programs has been utilizing an evaluation system that is based on normalization. It is based on quality of service and the rights of the individuals being adhered to and each program's community residence is not only evaluated on that instrument annually, I believe, but also the application packet for new programs is centered on the same quality considerations.

So that they know in the development process that the service is going to adhere to their quality program.

Q. You mentioned problems during your tour.

Did you determine whether there were any weaknesses in the system?

A. I think there are a few, but it certainly does not deal with the individual services.

It deals more with — they need to develop more community services. They need to have higher visibility to the mental-retardation concept at the base service unit level.

There needs to be more research and resources at the base service level, which provides the case coordination and the case management and coordination.

There seems to be available activity levels from various service units. Some were highly involved, others did not have enough staff to allow the services to expand a lot; so I think the independence
[6-63] and visibility and accountability of the base service units could be improved and more resources supplied.

Secondly, the support services, the availability of vocational-training services, the funding of vocational training — there seemed to be a slight problem that they totally relied on the funding programs for adults that came out of institutions.

These, however, are easily resolved. These are not major problems.

I think that as we increase community programs, that is residential, we are going to have to take a look at increasing the range and availability of vocational-training programs.

Q. What are your general impressions and recommendations as a result of your tour of the various community-based mental-retardation programs?

A. I think the two recommendations I just talked about.

The major one would be obviously to increase the number of community programs, to insure that there is a rational growth to those programs that allows for the stabilization and consistency of quality that we see now.

Second, that they take a hard look at the lines of accountability and the available resources for case

management so that we insure an ongoing monitoring and coordinating system, and the expansion of
[6-64] some of the support services like vocational training to insure that there are enough out there.

* * *

[6-95] **Testimony of Dean B. Settle**

* * *

[BY MR. RIVERA:]

Q. Do you know whether any of the mentally-retarded citizens can be gainfully employed?

A. There is no question about that. The National Association for Retarded Citizens, rehabilitation services of the Federal Government, through my own experience and professionals that I know, estimate as high as eighty-five percent of the mentally-retarded population can be employed.

Q. Are there any programs or services recognized in your field to help the mentally-retarded citizens achieve gainful employment?

A. My experience and my basic reason for being here is my relationship and my experiences in working with adults; and in the work with the adult mentally-retarded, typically, sheltered workshops, work activity programs, modified skill-training programs, and on-the-job training programs with appropriate supportive services are some of the recognized techniques for making mentally-retarded people ready to enter competitive employment areas.

Sometimes the supportive areas, of course, there are certain kinds of supportive areas that I can get into.

Q. Will you describe what you mean by sheltered workshops?

A. Certainly.

"Sheltered workshop" is a term that was given authority and credential by the Department of La-

[6-96] bor, in which, during a training or an evaluation period for someone who is disabled or thought to be disabled, a wage-and-hour exemption certificate is obtained for the sheltered workshop or for the work activity program allowing a training wage which is

characteristically a sub-minimal wage to occur during that training or evaluation period.

Q. From whom do you get this exemption?

A. United States Department of Labor, Division of Wage and Hour.

Q. You also mentioned a modified work station. Am I correct?

A. Yes.

Q. Would you explain that?

A. There were different types of service delivery for those individuals who are mildly impaired or who have minimal secondary difficulties.

A regular working station, much as anyone in this courtroom could handle, is the norm but we find in working with the population that I see the mentally-retarded adult and the multiply-handicapped adult, modifications of work stations and work-training methods are indeed beneficial and increasingly more common.

We would use industrial techniques, such as industrial engineering, some electronic modification, hydraulics, pneumatics, utilization of even bringing in some of the medical service people,
[6-97] such as occupational therapists, to maybe modify a wheelchair, and then the industrial type of people designing jigs, fixtures, modifications for the work performance to enable the individual to maximize his earnings.

That's the real goal.

Q. Will you give us an example of a modified work stand?

A. Yes, certainly.

In our workshop in Wichita, Kansas, we have a large contract from a firm that manufacturers aquarium filters for tropical fish. This whole contract now has been broken down into ten work stations.

The individuals assigned to that work station, each and every one, are multiply-disabled. They are mentally-retarded, moderate to severe in level, and also possess cerebral palsy conditions, possibly epilepsy. Some have hearings impairments or are deaf.

These people are now able to perform in a work setting and participate at roughly twenty to thirty percent of normal productivity rate with the fixtures applied in modified work stations.

Prior to that time they could not perform at all.

We are talking about modification, less than five percent of the productivity rate of the normal worker.

Some of the modifications would include a method — in fact, we have now, in working with the
[6-98] Rehabilitation Engineering Research Department at Wichita State University, eighty different activation devices. We can actually start a drill press by biting on a switch, by pulling on a switch, by passing a hand to break a light beam, by passing a magnet over another magnet.

There are all types of ways to perform work and the challenge comes to those of us in this field of allowing disabled, significantly-disabled, people to participate in the work ethic, with the limits to them that if we can modify their work station they were to begin to participate in something we value — real work.

Q. You also mentioned supportive programs.

Could you tell us what supportive programs are?

A. In the field of rehabilitation, in community rehabilitation facilities, work is the theme and there is no doubt about that. That is the primary training vehicle, but supportive programs are needed, such as social service, such as psychological services.

Years ago, ten — fifteen years ago, we would

have received community referrals and the individual would be mildly retarded and there would be no other secondary difficulties involved.

Today, with so much of the institutionalization effort affecting community services, we no longer see someone who is just ten percent retarded. We
[6-99] see someone who is retarded and has emotional problems or we see someone who may be mentally retarded and blind because of Rubella outbreaks or so on.

So we actually need other kinds of services than just providing work, so we need occupational therapists, physical therapists for people who have cerebral palsy, and I mentioned psychological services if they are emotionally-disturbed.

And then training individuals to live, and to live in the activities of daily living, living skills are specifically taught. We have a program in our center which teaches how to ride urban mass transit systems.

Q. Is that what you consider a living skill?

A. (The witness nodded.)

Q. Where should these programs be carried out?

A. The ideal place for training, vocational training, job training, in the community, is where the jobs are.

Q. Is there any reason for that?

A. The world of work occurs in your city, my city, in our neighborhoods. It is the normal, expected place for work to occur.

We see people every day that are living in various living arrangements, but come to our shops or come to a crew that we have placed in industry for intensive short-term training, and we even have a
[6-100] program called Projects With Industry, where we bypass totally the sheltered workshop and the individual goes directly to the plant and we pay the em-

ployer a learning wage so that the person can train actually in the plant.

Q. Where do these people live as you are teaching these programs in the community?

A. Living arrangements would be as diverse as the living arrangements represented by the number of people here in the courtroom.

We have people, of course, living with their parents. I would say as many as one-third of our people still live with their natural parents.

We have some individuals whose natural parents have died and they are living with a sibling, a brother or a close relative.

We have several that are in what we call a small home cooperative. This is a chain of adult foster homes. We have forty to fifty of these at a given time with no more than three people per home.

We also have contracts with eight group-home facilities and in Kansas no more than twelve people per group home.

We have many others who are living in their own apartments or who are living in apartments where, similar to Miss Glenn's testimony, maybe a
[6-101] staff person is available and they can be checked on daily or they can be checked on weekly or whatever the needs requirements of this mentally-retarded person are in that setting.

Q. Is there a reason for having these people live in a community rather than in an institution?

A. Well, first of all, living in a community is more natural and normal and if you are going to participate in the world of work that's where it is going to happen.

It is not going to happen in the institution, it is not going to happen in the community; and in the particular population that I deal with I cannot even conceive of it occurring in the institution. It must occur in the community.

Q. Now there are institutions that are programmed that offer the type of programs and living arrangements that you have just described located throughout the United States?

A. Certainly. In my professional experience I have traveled some and I have seen vocational programs with living options and appropriate supportive services in every state that I have visited, varying degrees of sophistication, but from California to New York and from Minneapolis to Louisiana it is a coast-to-coast proposition.

* * *

[6-106]BY THE COURT:

Q. By that did you see people in Pennhurst who, in your opinion, could be trained at your facility for employment?

A. Absolutely. There is no doubt about it.

In fact, I would say that I saw hundreds that could be trained in a community facility.

THE COURT: All right.

BY MR. RIVERA:

Q. Does your facility serve any mentally-retarded citizens with added handicaps?

A. Without —

Q. With added?

A. With added handicaps? I am sorry.

Yes. Our agency is a statewide agency and we serve all 105 counties of Kansas and there are some fifty other facilities in the State that serve mentally-retarded adults.

We have made it our business and we specialize in serving the multiply-disabled, the retarded person, so it would be very common for us to serve a

[6-107] mentally-retarded person who also has cerebral palsy, a mentally-retarded person who has emotional problems.

I think the last statistics that I looked at, twenty percent of our total population in 1976 had epilepsy, six percent were blind or were significantly impaired visually, seven to eight percent had significant hearing impairment or were, in fact, deaf.

* * *

[6-122] Q. How many contracts do you have in total?
A. Over a twelve-month period we would be looking at some 400 different, contracts in our shops.
Q. Okay.

Speaking of one contract, which is your largest contract?

A. The largest single contract that we have is one
[6-123] that goes back some four years. It is a contract that we have with the Federal Government and we manufacture forty-three different signs, legends, and decals that all of us have seen, such as the U. S. Army, Interoffice Motor Pool or Official Use Only — all this kind of thing.

These are vinyl pressure-sensitive decal signs and forty-three of those signs are made exclusively by our agency.

In fact, we obtained those contracts under the Wagner-O'Dea — it has been revised now, the Wagner-Javita-O'Dea Amendment, which allows for severely-handicapped, severely, non-blind handicapped to participate in Federal contracting; and we have proved our product to both the Department of Defense, the Defense Supply Agency, and to GSA, General Services Administration.

Q. Speaking of these contracts, would you briefly describe the different job classifications involved in selling this contract?

A. First of all, we are one of the few agencies in the country that has taken the Government work and has assigned it in total to our work-activity program, and I think that's important for the Court to know.

Q. In other words, all the work is strictly done by your clients?
A. It is all done by our clients and it is all done by our most severely-disabled clients.

[6-124] The contract on any given day will involve twenty-five clients. Out of that twenty-five, ten are cerebral-palsy, three are blind, and the rest are mentally-retarded and I would characterize them as being just moderately severe in nature.

There are three full-time staff people in addition to that plus a production foreman and a contract procurement person and then the industrial engineer that I mentioned to you earlier that would help modify the contract.

We still job out the actual die-cut, the actual printing of the letters. That is done at a printing plant in town.

The product then comes to us already die-cut and our clients remove the excess vinyl, proof the letters, and make sure that like the centers of the letters, the O's, P's, the A's, the D's — all of those are removed.

Then they are bonded on a machine and they are laminated and they are cut into strips or into square like if it is a single letter or a single number. They are cut into a specific dimension.

It is important to know that we meet military specs throughout the whole process, and then they are inspected and counted.

We use very severely-disabled cerebral-palsy, mentally-retarded people to visually inspect and
[6-125] then we use blind mentally-retarded to count the units.

Then they are bagged and sealed and from that point they go to a department that does not have any disabled in it, and that's our Quality Control Department.

One of the reasons we have been able, in our agency, to get good contracts and keep good contracts is because we make certain that the contracted stuff that we ship arrives absolutely perfect if we can at all qualitate it.

In the four years we have had this contract we have never had a rejection and since 1975, late 1975, we have been on fast pay. We no longer have to wait for a Government inspector to come. They trust us to that point.

The volume on this contract, by the way, is about $230,000 a year, so it is large business.

Q. And are the job tasks involved in filling the other contracts similar to the job tasks you just described for this one?

A. They vary. We would have some job tasks that would be simpler and we have other job tasks that are quite complex, such as in your electronics area.

By the way, that's in our work-activities program also, and in our metal shop this also would be a more complex kind of job function.

We do have some skill-training. These occur in service and clerical occupational areas. We train for food-handlers, we train for custodial and janitorial
[6-126] workers and in office areas, not so much with — yes, we have. We have trained like a copier, somebody that can run a Xerox machine. We have also trained in the operation of mimeograph, duplicators, mentally-retarded young men and women who want to do those operations.

We also have some of our emotionally-disturbed trained bookkeepers, but that's really not germane to today's discussion.

Q. From your tour of Pennhurst were you able to observe whether there were individual residents at Pennhurst who were capable of doing such tasks as you just described?

A. Absolutely. There is no doubt in my mind.
Q. There were?
A. Lots of them.
Q. From your tour of Pennhurst were you able to observe whether there were individuals who could be competitively employed in the community.
A. Again, I would have to answer hundreds of them could be competitively employed that are currently living at Pennhurst.

* * *

[6-129] Q. Getting back to your tour of Pennhurst, what was the purpose of your tour?
A. I had basically four professional concerns in touring an institution such as Pennhurst.

I was concerned about the habilitative programs of the adult patients that might be there.
Q. Excuse me for interrupting you, but could you define habilitative for us, please?
A. I would define habilitative as a developmental process in which one's total life skills would be dealt with, either in unison or one at a time, in order to bring one to a level of productivity where he might be useful not only to himself but to his community.
Q. All right. Continue.
A. I was concerned about the habilitative programs at Pennhurst.

I was concerned about the environment of the
[6-130] institution.

I was going to also review traffic patterns and lastly I wanted to verify and see for myself the movement from the institution to the community — was this happening? If not, why not? That kind of concern.
Q. Were you able to evaluate the programming done at Pennhurst?

A. Yes. I visited Pennhurst two days, did an awful lot of talking and walking and observing and later reviewed records after they were given to me.
Q. I felt that in general the programs that I saw and the records that I reviewed illustrated to me that the programs for the adult mentally-retarded at Pennhurst were inadequate.

In my conversation with Dr. Youngberg and other assistants that I had, by their own admission they felt that the average program — by that I mean planned, meaningful activity, structured, planned, meaningful activity per day for the adult population in Pennhurst would be no more than an hour and a half per day.

This is a long way away from a six-hour requirement, which would be the Joint Commission on Accreditation of Hospitals requirements for a structured programmatic day.

* * *

[6-146] Q. And what observations led you to conclude the physical environment was, I think you worded it, substandard and dangerous?
A. Most of the buildings that I toured thorugh were buildings that were built fifty years ago, approximately.

They were not accessible. They were either
[6-147] very cold or very hot, and we are talking about steam heat that was extremely difficult to regulate.

We are talking about sleeping rooms with only one method of egress in case of fire.

THE COURT: That also happens in new buildings.

THE WITNESS: The environment was certainly lacking in any redeeming quality that I can think of.

I recall one ward where forty-six beds were shoved together in one sleeping area; broken furniture in the day room and sitting area and, of course, the residents were locked out of the sleeping area because there was not sufficient staff to maintain order.

On one ward when we walked in with Dr. Youngberg somebody had lost their shoes, so the shoe box had been brought out into the middle of the day room and all the shoes had been taken out and all the shoes were in the middle of the room and everyone was looking for a pair of shoes. They thought there was a sale going on.

I question very sincerely the safety of those buildings with regard to fire. There were a lot of clothing that could burn; there was paper and trash in some of the areas. The housekeeping was not that good.

In some of the wards I asked how often they saw the housekeeping people or if they had housekeeping personnel assigned to the ward; and I was
[6-148] informed in two instances that they hadn't seen a housekeeper in three days.

In both of those instances I think there were housekeeping personnel assigned to the ward but they just did not show up for work. There was an absentee problem in a very critical area and that is maintaining sanitation and order and cleaniness in the area.

Even in the new buildings — I visited several of the modular units and I think this is important too.

I liked the layout of the units and I thought they provided some privacy and they were bright and clean and I felt very homelike for an institution to build.

But I was informed that the construction of those things had taken literally years, that the cost override was phenomenal.

In the first modular unit we went into the residents reports that they had not had any hot water showers for three weeks, so even in the new units there were some real problems as far as just creature comforts.

* * *

[6-149] I ask you to turn to Exhibit Number 48, the picture log, Pictures Numbers 102 and 103, and ask you whether there is an accurate representation of what you saw in Ward D-1?

A. Yes, it is.

Q. Could describe what you saw in Ward D-1 now?

A. This was a ward with forty-six non-ambulatory males. Almost every one in that ward was in a wheelchair.

Total staff for all three shifts were only sixteen. On the date of my visit there were four people, staff people, present.

There were no meaningful activities whatsoever going on. There was a television set up fairly high that was blaring away.

The day room was in the center of the two sleeping rooms. In this particular ward the sleeping rooms were not locked, but the residents were prohibited from going into the sleeping area.

There again it is poorly lighted.

I was concerned about how four people could get forty-six non-ambulatory people out in case of a fire. I just don't see that the basic fire and safety code could be adhered to on that kind of a staffing situation.

Q. Did you find the other wards similar to this?

A. I saw other wards with similar kinds of conditions, except that this was such an acute case be-

[6-150] cause they were all non-ambulatory.

Q. In terms of the conditions you have already stated, did you find similar problems at Pennhurst?
A. Yes.
Q. Were you able to evaluate Pennhurst in terms of physical environment?
A. Yes, I did.
Q. What did you conclude as to the workshops?
A. Well, workshops are usually something like stepsisters. They usually get the building that is about to be razed or the basement of the school; and the room that was loose, and I was not disappointed in what I saw in Pennhurst.

We visisted Building U, which I was told by Dr. Youngberg is scheduled for razing in the near future.

That building is an extremely depressing old building that does not meet even the basic standards of human occupancy.
Q. I will ask you to turn to page thirty-five, Picture Number 68, and ask you whether this is an actual representation of the workshop you observed in U Building.
A. Yes, it is.
Q. Could you describe the deficiencies you observed in this workshop?
A. Again, we are looking at a building that was not accessible.

This could not meet even minimal industrial
[6-151] standards. The aisles and passageways were not clearly marked; in fact, it was hard to tell which was an aisle and which was raw materials or finished goods.

There was no storage area so the goods either coming in or going out were stacked in the aisles.

Many of the machines were not properly grounded, not meeting the basic OSHA standards.

Q. Excuse me.

Mr. Settle, could you please tell us what OSHA means?

A. Occupational Safety and Health Act.

Workshops are involved in interstate commerce and we are subject to all of the safety rules and regulations promulgated by that act.

Q. Thank you. Just continue.

A. Lighting in some of the areas of the shops was not adequate.

The restrooms were not adequate.

The facility, as I say, was subject to soon be destroyed and no money had been spent in ages on just building upkeep.

Q. During your evaluation of the workshop in terms of physical environment, were you also able to observe and evaluate other workshops in Pennhurst?

A. The other workshops were, as I mentioned, in the basement of I Building, on the main floor of the school building.

[6-152] These were small units that were set aside for prevocational purposes.

Q. And how do they compare to the workshops that you have pictured in Picture Number 68?

A. In all cases, they were not in accessible areas and there was only one method of entrance there, for egress, for ingress and exit.

Q. Any other deficiencies?

A. As a result of the placement of the workshops on the Pennhurst grounds, there would be extreme difficulty in getting physically-handicapped people into the workshops. There is just no space, there is no room, there is no ramp. The doors to the restrooms are to narrow.

* * *

[6-153] Q. Mr. Settle, does the fact that the workshops are substandard and unsafe create any additional problems?

A. There are a lot of spinoffs from such a situation. One, obviously, they were extremely crowded so that there were people who needed workshop experiences who couldn't get into the workshop.

Secondly, when you have people that can't go into workshops, I assume they are being held elsewhere and they may have programs or they may not and the consequence of that would be behavior
[6-154] problems because they didn't have meaningful work to do, a lack of training opportunity, a loss of earnings, and probably most important, because most clients out there claim that no one has to work.

* * *

[6-163] Q. Mr. Settle, do you have any recommendations to improve overall conditions at Pennhurst?

A. Let me refer to my written report on this particular matter.

I honestly feel that at this point there is no need for further admissions to Pennhurst because of many of the things that I was concerned about.

I would recommend that vocational rehabilitation in the Commonwealth of Pennsylvania immediately a very aggressive evaluation and training and replacement program be set up in conjunction with or independently and related to those Pennhurst residents who are nearing readiness for community integration.

I recall one interview with one of the former vocational rehabilitation counselors, who was a unit chief, who said there are only three vocational counselors on the whole staff — 1500 and some people and only three counselors, none of whom were

functioning as vocational counselors. That was a civil service title.

I am concerned about that. In order to move people vocationally you have got to have someone in there who knows how to play the game.

I would recommend that the residents at Pennhurst be programmed immediately into a ma-
[6-164] jor program for the major portion of their waking day. One and a half hours isn't going to make for the people who are going to be ready for community integration. It is just not that meaningful.

The staffing that I observed at Pennhurst is not adequate. Additional supervision is needed and more attention to housekeeping. Those two areas are immediate concerns and, of course, the whole area of programming needs to be dramatically improved.

This next one, I am sure, has one horrendous price tag, and that is I think that Pennhurst, in order to be a safe environment, needs to meet all applicable life safety codes.

I found one figure yesterday that $21 million would be the pricing and I begin to look at the cost benefit of what I saw for Pennhurst in this particular estimate and I don't know that it is worth it, a very personal opinion at this point.

I would recommend at this point that Pennhurst not build any additional cottages on its campus and deal very honestly and sincerely in moving and integrating people into the community.

Finally, I would recommend the absolute prohibition of any restraints or isolation in Pennhurst.

While in D Building I did observe records and I did see the isolation room and I just don't see that
[6-165] there is any need for the utilization of such behavior-restraint.

[6-165] Q. Mr. Settle, if Pennhurst was to implement all the recommendations you have just made in your professional opinion would the habilitative needs of the residents then be met?
A. I am afraid not. It would still be a large institution.

It would still be a very non-normalizing environment. It would be a situation where regimentation is the theme of the day, where people are referred to by case number rather than by name, where people have to wait in line to get into the workshop, where people have to wait to get a patient-worker job, because the team has failed to act and send a pink slip down to Mr. Ingalls.

Those kinds of things to me would indicate that we would still have a very, very large unnatural institution with all the problems therein. It is not a normal setting; it is not going to produce a quality of life that I would want to see happen here in Pennsylvania.
Q. And what do you mean by normal setting and quality of life? In what terms do you mean that?
A. We get into, I think, some of the same kinds of things that Miss Glenn was talking about.

The whole principal of normalization is to not treat mentally-retardeds as some strange creature that is markedly different from you and I. Usually retarded people I know are more like me than unlike
[6-166] me. They have the same needs, the same desires.

They generally can follow the same life-style. They live somewhere, they work somewhere. Most all of the people I know can use the same generic community services.
Q. So then, in order for the habilitative needs of the residents at Pennhurst to be met, they should be provided with the services they can get in the community?

A. The community is preferred.

Q. Mr. Settle, you have mentioned the community.

Have you had an opportunity to evaluate the various community services available in Pennsylvania?

A. Yes.

Q. When did you have this opportunity?

A. On February 24 and 25, 1977.

Q. Do you remember where?

A. (There was no response.)

Q. In what area?

A. I toured programs in four of the five counties in this region. In all four counties except Philadelphia County — Delaware, Montgomery, Bucks — and then I am neglecting the next one, I can't remember the fourth.

Q. Chester?

A. Chester County.

Those are the four counties that I visited programs in.

[6-167] Q. What type of community alternatives did you evaluate?

A. My visitations again were limited to looking at programs serving older teens or adults in vocational settings or in related living arrangements, so I looked at schools for severe, moderate, and profound trainable handicapped people operated by intermediate units.

I looked at sheltered workshops, several of those.

I visited a vocational technical high school, in which there were special classes integrated right into that building.

I also visited a corporation that operates foster homes and group homes for mentally-retarded. I also spent two or three hours one evening in such a home visiting with the seven ladies that lived in that home.

Q. Will you tell me the procedure you used in evaluating these various programs?
A. In almost every incident that I can recall I talked to either the program director or the executive director of the agency.

These tended to be either public-school operators or private non-profit entities.

I talked briefly about their program goals, their program philosophy, a little bit about who they were serving, where they came from.

[6-168] Then I reviewed records, I talked to staff, I talked to many of the students and many of the workers that I met in the community programs.
Q. In your professional opinion were the programs you observed or did the programs you observed cover the range of community services that would be necessary if Pennhurst residents were to placed within the community?
A. Yes, they did.
Q. What sorts of citizens were served by the various community programs you observed?
A. In my tour of the facilities in the four-county area I observed mentally-retarded receiving training in services from the profound level, such as the ones I observed in Summit School. I think there were about forty such individuals in that school whom I characterized as profound up through some very mildly-impaired individuals in some of the workshops and work-training programs.
Q. Were any ex-Pennhurst residents in the various programs?
A. Dozens. The majority of the people in the group home came from Pennhurst.

In the Bucks County workshop I believe twenty to thirty had come from — which would be a majority of that center at the time of my visit.

In the schools some, not large numbers of people, but some had been at Pennhurst.

[6-169] Q. As a general observation would you say that the Pennhurst residents were able to function within these community settings?
A. They were, yes.

* * *

[6-170] BY MR. RIVERA:
Q. Could you describe the program of the Summit School?
A. Yes. This was an excellent school. It was operated by an intermediate unit.
[6-171] It had, as I recall, about 180 to 190 students. All students in this particular program were fed into that program by other schools within that county district or within that intermediate district.

All of the people in this particular school had IQs under fifty, so we are talking about someone who is significantly impaired intellectually and we are talking also about a lot of multiply-handicapped people. I saw people in wheelchairs, deaf people, some who had visual impairment, some blind as well.

They served people all the way down to about three years of age.

In my conversations with Joan Beck, who was the supervisor of that school, the vast majority of these people lived with their natural families. A few lived in foster homes and I think she said three in group homes and maybe one or two in St. Edmonds Home or Hospital, I am not sure what it is called.

I just felt that it was a very, very well-run facility for a very severely-handicapped group of kids.

BY THE COURT:
Q. What was the address of that again, if you recall?
A. I don't know that I — as I recall — I am sorry, sir. Your Honor, I don't have the address on my tongue and I cannot recall it.

THE COURT: All right.

[6-172] BY MR. RIVERA:

Q. Do you remember what type of individual programs were being run within Summit School?

A. It was set up as a school, so they had various classrooms. There were several dozen special education teachers.

In addition to that, there was again almost for every teacher an aide, so there was, I find, an excellent staff in attendance.

Then over and above the teacher and your aide staff competency, they had specialists in language development, in speech and hearing, in sign language, in vision consultants, psychologists, and social workers. They had a nurse.

I felt that it was a very, very well put together professional team that could look at a child and assess his assets and limitations and work with the school and the family for a very good plan.

[6-173] Q. The next community program you mentioned was the training class at Central Bucks School; is that correct?

A. Yes. This was a new experience for me.

In our part of the country, in the Midwest, I have not visited that many technical vocational schools where trainable mentally-retarded, the people that again would be in the low fifty IQ, had been integrated into a vocational technical setting.

I went to this beautiful, brand-new technical-vocational high school located in Bucks County and was taken to the second floor classroom, which was right alongside of a lot of other classrooms, walked in, and met a teacher who had an aide, and he said that his capacity there would be about twelve students.

At the time that I visited his class he had nine — eight young men and one young woman — in his class.

He had a talk that lasted about four hours getting into communication skills, reading for living, and excess who go hot and cold and those kinds of things, so that a trainable person could begin to exist comfortably in our world, which is somewhat essential.

[6-174]

He got into some stimulative work. He got into a little bit of recreation and physical development and then the really surprising thing is something I felt was very exciting.

These kids then had a chance to go into things like auto mechanics, into horticulture, into cosmetics, cosmetology, and into some of the other manufacturing areas and actually get experiences with the normal student in that setting.

It was a real knockout. I thought it was a very normalizing, a very healthy kind of situation.

If the person couldn't handle it he could always come back to his home base. If the person had difficulty integrating into the class the teacher would send the aide to kind of work as a buffer and as an introductory person for the young adult.

I thought it was an excellent program.

Q. What about Bucks Vocational Center? Would you describe that program for us, please?

A. This particular sheltered workshop was one that I visited on my last day and it was located in Bucks County, in an industrial park, in a brand-new building.

Q. Are there any advantages to have such a vocational center located in an industrial park?

A. It is an extremely proper and normal place to put a workshop, where you get real work from the community; and having a workshop in an industrial park is exactly where it should be in my opinion.

[6-175]

Q. All right. Continue.

A. In this particular shop, it had been previously located in another area and they had just recently got-

ten additional funding and had rented this large area and had been serving, I believe, about sixty people on the day of my visit.

I was told that out of that sixty thirty had been in Pennhurst previously. I was also told that by July 1st another additional number of twenty were to be transferred to them.

BY THE COURT:

Q. From Pennhurst?

A. From Pennhurst.

Of necessity I saw, I would estimate, that about ninety percent of those were mentally retarded. They had a few individuals who were emotionally disturbed or blind or had some other primary disability besides mental retardation.

They had services in areas of vocational workshop, occupational training. They had some specific skill-training in food-handling and they had two others on the drawing board, janitorial and material-handling training, that I think by this point would be operational.

He had a staff of twenty-two and an annual budget of almost a half a million. It was a very, very
[6-176] well-equipped, pleasant, attractive environment.

BY MR. RIVERA:

Q. The last one you mentioned was Drexel Hill; is that correct?

A. Yes. This was a group home operated by New Challenges, Incorporated.

Q. Mr. Settle, could you look at U. S. Exhibit Number 48? I ask you to turn to page thirty-one, Photos 59 and 60, and I ask you whether these are an accurate representation of what you observed at the group home at Drexel Hill.

A. Yes, it is.

Q. Could you describe that program?

A. Well, it is a home in just a residential area, in which I observed seven women, I would say in their

twenties, who resided together. They were all unrelated.

They had one person employed by New Challenges who is functioning as the house manager.

The women in this particular home, seven ladies, all of them worked in workshops or in rehabilitation centers.

Four had come from Pennhurst.

I would characterize these ladies as moderately-retarded.

The important thing here is that they lived on a street like my street; they used public transportation
[6-177] to get to work; and they were all earning their own money.

They were showing me clothes that they had purchased with their earnings, television sets that they had saved money to buy, and some other really neat things.

The home's mascot was a beautiful Afghan hound, which everybody flipped coins over to take for walks. One of the girls upstairs had a couple of parrakeets and, believe me, you don't see this in Pennhurst. There would be no way to have such pets on the ward.

Q. Mr. Settle, before continuing, is the Summit School the one located in Wallingford, Pennsylvania?

A. That is correct, thank you.

Q. Mr. Settle, from your evaluation of all the community services, including the four that you just described, is there an advantage to offering these programs in the community rather than in institutions?

A. There is no question in my opinion the quality of life that these people enjoy in the community is far superior. They have many, many opportunities to learn, to observe, to model their behavior, to improve their behavior by associating with non-handicapped people in the community.

It is a tremendous advantage, I think, to be in the community close to one's relatives and parents.

I recall a conversation with Dr. Youngberg, where he said only maybe a third of the parents at
[6-178] Pennhurst were really actively involved with their resident out there.

Part of that is the isolation and part of it is what parents have to go through in order to institutionalize their retarded person in the first place. It is a little bit like somebody dying.

BY THE COURT:

Q. In your testimony you have indicated that several of these community facilities that you visited had a number of those attending who had come from Pennhurst.

A. Absolutely.

Q. Did you have an opportunity while you were at Pennhurst to ascertain why more residents of Pennhurst were not being funneled into these local programs?

A. There were several, several areas of concern, your Honor.

One would be the failure of the community to provide simultaneously both a place to work and a place to live, some kind of failure to coordinate fifty places in a workshop with fifty places to live. Somehow that doesn't happen.

Maybe under the same corporate auspices, or maybe the State's funding of those things —

Q. Do I understand that the facility which you operate has residents from areas provided by the school?

A. We do not operate in those directly. We contract with forty home operators and eight group operators.

[6-179] Q. In the vicinity of —
A. They are all over our county. Those homes are in forty-eight different neighborhoods.
Q. How do your trainees or students get back and forth?
A. Our Metropolitan Transit Authority — they use our State bus service, with the exception —
Q. In order to take advantage of your training facility they at least have to reach the stage where they are able to, we will say, live in one of those residences in the community and also to use local transportation?
A. We will match the person to the residence, and some of our residences prefer the workers very close to their work. They like that sort of dependable person.

Then we would actually train the person to ride the bus.
Q. I think I probably interrupted you when I asked you the question if you had been able to ascertain why more residents at Pennhurst weren't funneled into these local training programs and you had answered partially, as I recall.
A. Let me return to my thoughts on that.

I was concerned, I think, about maybe the lack of coordination between the development of vocational services along with housing. I see that as a real problem, not only in Pennsylvania but in my state. I see that as a common problem.

I also fail to understand why Project 256 has
[6-180] not been kicked off. There are millions of dollars that have been made available for it, for the Pennhurst residents to become integrated into the community and that seems somewhat slowed down or lost in the bureaucracy, and I would hope that whoever is responsible for the slowdown can build a fire under those people who can make it happen.

There is no reason why I can see why these dollars can't make room for hundreds of people in Pennhurst in the community, open those group homes, maybe talk about adult foster homes.

They can serve a lot of people for less money and provide very intensive, almost one-to-one, care on that kind of a basis.

Then, for every group of homes you open you could open some workshops and you need some case managers to make sure that these people have an advocate and get the services that they need to get and that the quality of the program in that home and that workshop is proper.

It is not that difficult; it is being done.

* * *

[6-183] Q. Let me just ask you a question.

In the various retarded citizens that you saw in community services, in your professional opinion as an expert, how many of these people that you observed would be potential Pennhurst residents if the community program did not exist?

A. That is an interesting concept.

A lot of the people I saw, for example, at Summit School — if it weren't for Summit School or something like that, I think the parents would have very few other alternatives.

If the community doesn't have answers for par-
[6-184] ents who have significantly-impaired kids, the only answer for it is the institution, so those facilities do prevent institutionalization.

* * *

Supreme Court, U. S.
FILED
OCT 30 1980
MICHAEL RODAK, JR., CLERK

Nos. 79-1404, 79-1408,
79-1414, 79-1415, 79-1489

IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1980

Pennhurst State School and
Hospital, et al.,

Petitioners

v.

Terri Lee Halderman, et al.

Pennsylvania Association for
Retarded Citizens, et al.

and

United States of America,

Respondents

**ON WRITS OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT**

JOINT APPENDIX
VOLUME III, A538-A694

**Petitions for Certiorari Filed March 12 and 20, 1980.
Certiorari Granted June 9, 1980.**

THE LEGAL INTELLIGENCER, 66 NORTH JUNIPER STREET, PHILA., PA. 19107 (215) 561-4050

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**Qualifications of expert witnesses were stipulated pre-trial. Curriculum vitae designated as PARC and US Exhibits, detailing education, experience, publications and other qualifications of all plaintiffs' witnesses are found in the Final Pre-Trial Order filed at R. 464, March 31, 1978.

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Testimony of Gunnar Dybwad

* * *

[7-50] MR. GILHOOL: Dr. Dybwad has been qualified as an expert in mental retardation, in the care and treatment of mentally-retarded people, in the administration and management of residences and other services for the mentally-retarded, and the sociology of the families of the retarded and in the comparative aspects of such matters across nations and across decades.

DIRECT EXAMINATION

BY MR. GILHOOL:

Q. Dr. Dybwad, have you visited Pennhurst recently?

A. Yes. I spent March 19th from about 9:30 to 5:30 in the afternoon at Pennhurst.

Q. And what wards of Pennhurst did you visit?

A. Well, I have a map here. I visited about half of the buildings and maybe about one-third of the wards.

Q. Did you visit the modulars?

A. And every one of the modulars, two wards on the
[7-51] New Horizons Building, one ward in the hospital, Q-1, D-1, D-2, T-1, W, M-1 and M-2.

Q. Have you previously had occasion to visit Pennhurst?

A. I have been in Pennhurst over the past fifteen years on various occasions, some specifically to visit; others because there were hearings or other meetings there, so I have been there at least six times.

Q. And what was the distribution of those visits across the last fifteen years: In what years?

A. I think they were more frequent in the 1960s, particularly the second half of the 1960s, when I was very much involved up there.

Q. When was your last visit before this 1977 visit?
A. I think it was either in 1969 or 1970; I am not quite sure.
Q. How, Dr. Dybwad, does the Pennhurst of 1977 compare with the Pennhurst of the late 1960s and before?
A. Well, of course, there have been changes made, some new buildings, and certainly some of the worst conditions of the late sixties have been improved.

You no longer find the kind of extreme unfriendly conditions which one found in those days, with feces around. I certainly found, for instance, the toilets are much cleaner. I even found soap in two of the wards.

From the outsider's view I looked at some of the refurbished wards. Pennhurst does look not quite
[7-52] the same as it did in those years.

But I have learned, as I look at institutions, and I do so with fair frequency, I try to look through the eyes of the residents, the residents' perspective; and from that viewpoint you still have a stultifying and essentially a dehumanized environment.

There is no visible wall or fence around Pennhurst, but it is certainly an invisible fence; it is a segregated community. One is in there, shut off from the world.

I know that some people have passes to go out, but essentially it is a closed institution with an environment where some of life's most basic satisfactions — eating, for instance, still takes place under very unsatisfying circumstances. One's senses are still being assaulted — the smell, the noise, the visual distortion — and this, you see, is for the very people who are in Pennhurst supposedly so that they develop to have a basic sensitive experience.

The noise level, which assaults, of course, staff as much as residents, puts really a burden on every-

body. Getting used to it means you continually scream to get on top of the noise. It really lowers one's expectancy.

From the sight viewpoint it is still an ugly place. The hallways, the inhuman dimensions of the spaces where people are supposed to live — the hallways, the corridors. It is more like a bus station
[7-53] than like a place where you or I live.

It is clean, but that does not change — a clean bus station.

Crowding has continued to be a very serious problem, I know. I know that much of the present crowding is doubling up while part of the institution is renovated but again, you see, from the administrator's viewpoint and from the outsider, that's an acceptable explanation.

But for the people who live there doubling up means that they are twice as crowded than they used to be, and there is very little comfort for the person who lives in those circumstances to know that sooner or later somebody else will be in a repainted and refurbished place.

Q. What about the activities in 1977 there as contrasted to previously?

A. Very much in evidence now are activity charts. You find them —

I always try to visit offices and not just the wards and you find in every office there hangs a wall chart with activities, and certainly there are activities listed there which one would not have found at the time of my last visit.

But when you look at individual residents — and what I do in such cases is that I notice some-
[7-54] body on the ward and I say could I see the particular chart? Then you can find it and when you study the ward chart, while you find there are activities on some, particularly some of the wards, there are a

good number of people for whom there is either no activity but a minimum activity.

Now I visited on Saturday, so I was not able to actually go out with the group and see what kind of recreation was involved when it said recreation, or what kind of therapy activity.

But the activity on the wards I could observe and that is still inactivity. There is very little that actually is going on, or to some extent it is really destructive activity, either by its acts of nature or by the total inactivity. In other words, you can be inactive huddling in a corner to such an extent that it is really destructive.

I don't want to make too much of incidents because, you know, they happen continually when you have such a large group of people, but in one ward, which happened to be on M-2 in Unit 5, there were a group of young, obviously aggressive persons, and one of them just kept on hitting another. The two attendants were really helpless to handle the situation until they decided to divide the group, and the woman took a group of them outside, which left the man with a smaller group.

[7-55] But on this ward at that time we visited there was absolutely no activity. You might say the only visible activity was this one boy.

So on the wards, the ward situation is still extremely unsatisfactory. Outside of the television you really see no visible signs of activity that could be carried on.

Q. Were many people outside on that Saturday?

A. A rather few. I just said the ward attendant took a few of them out, but as we walked around the grounds, and we covered a lot of territory, no one could see — and it was a Saturday, and in a way I think more people would visit institutions on weekends. Weekends for us are recreative days. I mean

we play golf or bridge or read books or go to movies or listen to good music and so on. In institutions, of course, they are the dreaded days with a curtailed staff, a minimum of activity, and outside of those fortunate few who have visitors, Saturday, indeed, is a dreary day.

I will admit I visited Pennhurst at an unfavorable day but again, you see, from the viewpoint of the residents there are fifty-two weekends in the year and this is the kind of routine.

Q. You mentioned some physical changes, improvements at Pennhurst, between the late 1960s and 1977.

What were your observations with respect to those?

[7-56] A. Well, the most disturbing visible improvement is a new building called New Horizons, which is really almost a travesty because it is a throwback to the worst of institutional architecture. It is the last building outside of the modular things, and this last building is an architectural atrocity beyond redemption.

There is nothing you can do with it. It is laid out in such a fashion that the living spaces, the dormitory spaces just can't be changed.

You would never think of human beings living there. You might store things in such a building and so on, but it has no connection, it is built solidly, although I believe there were some technical problems before it was opened.

But to me right now it looks like a solid building. Technically, you would have to say this is an improvement, a new building has been put in place.

Again, from the point of view of the residents, it is a totally unacceptable environment. There is nothing human about this — the floors, the walls, the total sterility. It is a mechanized environment. It

is out of the human scale, and to me, who has worked in the field of architecture for a good number of years, it was a very sad commentary on what we think of people who live in these institutions.

[7-57] Q. What of your observations of the modular units?

A. The modular units architecturally are quite acceptable. Again, I know that there were some technical difficulties about their opening but architecturally, although I wish they would have been duplexes, that they had cut them in half and made little, smaller units, but the rooms are all right. The general appearance certainly is on the human scale — single, double rooms, some sitting rooms and so on, some nice sitting rooms and so on.

But I was reminded of something that happened some years ago in Idaho, at a training school, following a visit of Mr. Bump Nicholson, who is the Danish Mental Retardation Director, and some later visits by me. The superintendent, a pediatrician, decided he ought to get some smaller units. He did something we could never do here in the East.

He just went to a local contractor and bought eight houses, prefabricated houses, and put them on concrete platforms and used normal human housing.

It was a great achievement, but the satisfaction didn't last long because the staff said if they can live in these houses here on the grounds, in this isolated environment, why don't they live in such houses in the community? Why did we build them here?

I am telling this to point out that, of course,

[7-58] what is wrong about the modular units in Pennhurst is that they are on the grounds of the institution, part of the institution, engulfed by the institution, so when you went through a good number of these potentially attractive places you found rooms that were barren.

There was furniture in them. One room looked like the other, really, no visible signs that people lived in there, no family photographs and so on.

The kitchens in there — the food is brought in and I always like, again, from the administrator's viewpoint, to judge by the menu the dietitian submits. I like to take a spoon and taste, and always after permission; so in these new houses, this new home environment where great effort has been placed, the food was cold as it came in and I had it before the residents did.

So obviously, even within the modular units, there are the problems that are forced upon them because of the problem, and I am fully sympathetic, of a dietary department to cook meals and deliver them all over the grounds. This is what you are getting.

You asked me about the modular units. I wouldn't just say too little too late, but in the wrong place, in the wrong place.

Q. Dr. Dybwad, you first visited Pennhurst in 1959?

A. Well, it may have been earlier, it may have been.

[7-59] Q. Have you, has your criterion for judgment of Pennhurst and such institutions changed in the interim?

A. Oh, yes. Oh, yes, definitely, and I have to explain this because I have written quite a bit on the subject and I have to eat my words, and it is a steady diet.

All in all my comments on Pennhurst are much harsher today than they would have been five years ago or thirty-five years ago, strange as it may seem, because a lot has happened and the reason for this is that I have grown more and more intolerant of the institutional environment in proportion for what I keep on learning about the developmental potential of mentally-retarded persons.

In 1959, when I did begin writing extensively on the reform of institutional care for the mentally-retarded, I still believed that environmental and programmatic short-comings could be remedied to a sufficient degree that it would benefit the residents, and the sufficiency of that degree has something to do with my perception of the potential levels of functioning on the part of the individuals with severe and profound mental retardation.

My expectation for these individuals in 1959 was so low that I found it a quite adequate answer if you would just have a little smaller institution, smaller wards, more humane surroundings, maybe get rid of the tile and have more normal wall
[7-60] coverings, more normal drains in the middle of the floor, more activity. These schools to me seemed quite reasonable and adequate.

But since 1959 I, and I think a good number of other people, have learned a lot and much of the learning has come, interestingly, not from learned colleagues or books but from the mentally-retarded persons themselves by their ever-ascending level of accomplishments.

And this is particularly true with the group we refer to as profoundly retarded. They have been particular subjects of a lot of misinformation. Let me exemplify it.

A good number of years ago I read in the English literature about a young man, profoundly retarded, — idiots they are still called in England — who had been able to be placed in what they call over there a hostel, a large group hostel. He was interested, and I have, on each one of my visits — and I visit England practically yearly — made it a point to see this young man. He has a mental age of two. He has no speech whatever. He is physically handicapped. There obviously is a brain injury.

He is the kind of person who would be lying around in most of our institutions, or who used to lie around, and yet I have seen this young man, as I say, yearly. He is dressed like other human beings. He lives in a community residence. This is now at least seven years.

[7-61] He participates very inadequately in a workup program. Unfortunately, that's the only place they have, so they cut a little niche to keep him busy. He is one of the persons who can't be productively employed, but he can be engaged in activities and he is.

The main point is that when last I saw him a few months ago I saw him in the dining room at the head of the line, with his tray, ready to go and have his lunch, which he was eating in a small dining room in this workshop with the rest of the young men and women.

I also went over to the hostel and looked at his life there. He is a human being and when you see him he might attract your attention. His motions are slow, you see, maybe a little vacant expression, but it was less. You see, he lives, a very limited life to be sure, particularly since he was, so to speak, rescued. He was supposed to have been committed to an institution and somebody intervened.

He never had any kind of training throughout his adolescence, so he is extremely disadvantaged, but is this type of a person who is able to live in better surroundings and, of course, that depends on the stimulation of the surroundings.

Now I know, and I want to make this point, that in our institutions a lot of training is going on and I am very interested in new behavior-shaping procedures and so on and what good schools and institutions very often have as the program.

[7-62]

But the horrible thing is once they have gone through the programs they go back to the wards. We have trained them to live like normal human beings and excellent work is being done, I want to emphasize this; but then they go back to the ward where they sit on toilets without seats, six in a row, no privacy, in places that just don't smell, don't look like normal habitation, so it is from this viewpoint — it is from this viewpoint that I am sorry to say that Pennhurst just won't do.

Q. Dr. Dybwad, you have visited institutions in forty-nine of the fifty states and in thirty-five countries many, many times; is that correct?

A. Yes. I never got to Alaska.

Q. Will you tell the Court how Pennhurst compared with other institutions around this country?

A. I think on any rating scale Pennhurst would be in the bottom category, joined, unfortunately, by many such institutions, certainly by every one in my own state of Massachusetts, certainly by most of the institutions in New York State, notwithstanding the twenty-five or thirty thousand dollars per person that they are spending now.

The changes, of course, that have been made in Pennhurst have been made in the other institutions too because they have had an increasing pressure partly from federal reimbursement, partly because state health departments have become concerned and so on.

[7-63]

Much of the changes have been in the sanitary area and we have better health protection, better fire protection, the condition of showers and all.

You may recall that in Pennhurst we had some sad history of people getting in horrible accidents around showers and so on. These kinds of things have been remedied.

But when it comes to the basics, still all of these institutions are characterized by a very limited program, and for at least some of them that is too kind a word. They still have basically the kind of dehumanized building which differs totally from the kind of building you and I are using or they could use and do use in the community.

They still are characterized by an isolated location, by the size of the institution, and by the essential character of what government calls a closed institution.

I think there is increasing realization not only in this country, but certainly in those countries like England, which have this condition of large institutions.

Some of the more backward countries are far ahead. They never had the large institutions; they can move much more rapidly into something else.

There is growing realization that this is not the
[7-64] kind of place for people to live in. It is depressing, demoralizing.

I want to make this point because I have worked myself in institutions — depressing and demoralizing for the staff too to live with the smell, to live with these masses of people, to live with the noise, to live in this deprivation; so I, of course, am sympathetic to the staff.

It is just that the main weakness is that these institutions, by dint of things that I have mentioned to you just render human beings and habilitation very difficult if not impossible.

I have been an institution man since 1929. I come from the prison field and I worked in reformatories and juvenile training schools and then essentially, since 1938, in institutions for the mentally-retarded; and I have left so many, many changes, and until recently I remained really seduced by what I thought we could accomplish.

I always — you know, I organized in 1966 an international architectural committee and have been very active trying to help the states. Interestingly, it wasn't the bad conditions and our inability to do much about them which have changed my mind, but it has been the repeated and even more evermore impressive demonstration by children and adults with mental retardation of their capacity to live and grow, once we keep them free of the depressing institution-looking environment.

[7-65] You see, as long as I could blame the bad conditions on the institutions my energy and that of my colleagues was geared to two remedies — carpeting, better wall covering, all of these things, more staff; but now our energy is really directed to the creation of liberating human and humane environments in the community with the final objective of closing down institutions.

And I want to tell you quite frankly that it is my absolute conviction that we are seeing the last years of institutions. To spend in New York now $33,000 a year — the rates are going up continually — for what everybody agrees is inadequate care, is becoming, not just from an economic but from a logical point of view, an absolute impossibility.

But my main point is we now know we don't need these institutions.

Q. Do you have an opinion, Dr. Dybwad, on the question of whether varying the size of institutions or staff ratio or the rest can significantly change what happens at those institutions?

A. Well, I think studies have been made now, and interestingly, those in the field of vocational capacity of the mentally-retarded and in the field of institutional management, the British have been far ahead of us and so certainly we have studies from England.

[7-66] They started out with Jack Tizard in 1958 and a

group of youngsters out of an institution — hostels they called them — in London and placed them in small residences.

I was able to visit him in 1958 and saw his experiments and he and his colleagues — Dr. King, Dr. Rains, and later Dr. Cushing — have continued to lay the groundwork for looking at institutions from a different standpoint.

Now some people in the United States become interested and said can't we do this if we simply cut down the size? So recently three Americans — Bella, Butterfield, and Zigler — all Yale-related — studied four institutions with strikingly different populations, from a few hundred up to two thousand, and also with quite different per diem expenditures, so there were some good institutions in quotation marks and some not so good ones.

Yet they all showed the same similarity. The institutional cult, as people called it — it is really not a good word, it isn't much culture, but the strange patterns of mealtimes and of sleeping and of the non-verbal, the non-expressive life that characterizes people in institutions.

There was some growth, but a very slow pattern of growth; and later on Zigler and some other of his colleagues even compared the Swedish and
[7-67] American institutions because the Swedish institutions are just the same though maybe there they can find institutions who will give us the answer.

But again they found that when you compare institutions of whatever size — of course, typically, in Sweden — we have larger — forgive me, we have smaller units, smaller institutions. When you compare them with the kind of informal community residence, then you discover that the institutions are characterized by gross deficiencies in the quality of life.

In short, all these studies show that the quality of human interaction between residents and the staff and between resident and resident are really the key factor. It is not very surprising. After all, education — everything we are is human interaction, but it is interesting that even if we cut an institution of three thousand down to three hundred, which is a monumental task, people have tried to do so and are not even halfway there, we are still having this problem.

Again, I say, even if we install carpeting and Simmons mattresses and increase the staff, improve the training, we still come up against this terrible problem of creating a human dimension in an institution.

Q. In your opinion, Dr. Dybwad, is Pennhurst the least restrictive setting in which the people there can live?

[7-68] A. Let me answer this rhetorical question with a no.

Q. Is it the least separate setting in which the people there can live?

A. No. Of course, I realize that everywhere we are growing in this country and some of the extreme isolation of our institutions has been removed, but essentially Pennhurst, of course, is a separate place. As I said earlier, there is no visible fence around it, but it is fenced in.

It is a place that is separate by the way people live there during the day, by what they do, by the way they are dressed, by the way they walk about. It is a separate place for human life which sets it clearly apart, and I think setting it apart would mean separateness.

Q. Is it your testimony then that all the people at Pennhurst, including the severely and profoundly-retarded and multiply-handicapped can live an inte-

grated life in the community and need not live in such separate and isolated environment?

A. Absolutely, no question about that.

Let me quickly point out that usually people are going to say, "But what about those in the back ward, the people who are moderately handicapped or profoundly retarded?" I can move them out quicker than any other people.

Q. Why is that?

A. Because what they need basically is a small stimulating environment in a situation where their
[7-69] physical needs receive attention and, by the way, whether they will get adequate medical care — and I think I can state without fear of being contradicted that throughout the country the medical care in all institutions had been atrocious. It has been documented in medical journals. We haven't been able to provide decent medical care.

Take any group of thirty records at random from any institution and you will discover conditions that have not been remedied, that have not been — it appeared that somebody wasn't there and so on.

Q. How does residence in the community affect that condition?

A. Well, let me point out maybe here what I mean by community placement.

One of the more forward-looking states at the moment is Michigan. Michigan has taken such individuals from institutions and others from the community, people who we would call in the old institutional parlance crypt cases; has placed them in individual foster homes, not just a few of them. I am speaking, for instance, because I know it very well, of Macomb-Oakland county. Macomb is the county around Mount Clemens. This little area has 140 of such homes and I made it a particular point of asking about it very recently.

More than sixty percent were profoundly-retarded individuals and more than eighty percent were highly handicapped.

[7-70] How do they do this? First of all, they pay a decent rate of board and room and no longer expect such citizens to subsidize the state, as it has been in the past. I come from the ( ) field. We always expect the foster parents to subsidize the state because they are so afraid, the state, that you might make some money; but now Michigan has done something very simple.

It says to these people, who are, of course, carefully selected, look, this individual has the following needs and these are the priority programs for him. Will you undertake one of these programs — toilet-training, maybe; feeding stimulation, physical exercise under supervision of the physical therapist.

There is a wide range of things and they get paid for it; and for a fraction of institutional costs every day — usually it is, of course, a woman — the woman — I have been in some of these homes — will work for one hour. Now how many people in our institutions would get an hour's actual individual attention in any one of these remedial programs?

This has been going on now for a sufficiently long time and, by the way, in Macomb-Oakland now they have, because the powers that be, not just in this state, when we built the New Horizons, but practically throughout the country, are still building-oriented. We always build buildings and in Macomb-Oakland they were supposed to have an [7-71] institution of six hundred and Dr. Rosen, the director, got it reduced to ninety, so he has ninety beds available to him.

In the past three months he had reason to once admit a person from the community for two days. Otherwise they have completely liberated them-

selves there. The population is about the size of Philadelphia.

Q. Is the idea of severely and profoundly-handicapped and retarded people living in the community a new one?

A. No, of course. Many parents have kept them, have had them home. In London I have seen for long — many years ago already — they had special-care centers. The people lived at home.

London, when money never was plentiful, felt it was good economy, actually, for some of these youngsters to call by ambulance and bring them to the day centers, to the special-care centers, forgive me, and bring them back in the evening; and during the day these youngsters had attention by physical therapists, developmental specialists helping with their development and so on.

Now, of course, we always had such people live in the communities.

Q. Has the experience of such people in the community, whether always there or returned from institutions, been subject to study and evaluation over the years?

A. Yes. Probably one of the most interesting studies in our country was the study by Sanger entitled, [7-72] "The Adjustment of Severely Retarded Adults in New York City."

Q. And when was that study?

A. He made the study in 1957. New York City was one of the cities in this country with very early classes for children below the so-called educable level. They were called low IQ classes.

He, with generous support from the State of New York, identified over 2,000 of such individuals who had left over a period of twenty years, and they took a sample of conduct, that we followed closely with the help of the social staff. The surprising re-

sult was — mind you, there were days when we had no community services, we had no support services, parents had no help whatever, we had no community mental health centers or anything like that.

The surprising result was how many of these individuals somehow managed to live at home, were out on the street; how few of them had gotten in trouble. We always had visions of that individual either becoming criminally involved or sexually involved and in neither dimension was this so. They had maintained themselves.

Of course, a good number of them eventually went to institutions but more than half had remained in the community.

The interesting thing was the older they became the better were their adjustments. In other
[7-73] words, even with the adults there was a continuing ascendancy. They became older, they become more mature.

I have another theory about this. They look older as they, you know, look a little bit more adult. With the first gray hairs they were treated with more respect by the community, which was sort of a changing factor.

THE COURT: I haven't noticed that difference myself.

THE WITNESS: The counsellor didn't mean it.

So that, yes, we have such studies. An earlier one was made, as a matter of fact, very early in this century by Dr. Tunnel, who was superintendent at the Tunnel School in Massachusetts; really, he recanted, he recanted publicly.

He hid the study for several years; he couldn't believe it.

BY MR. GILHOOL:

Q. What was it that that study showed?

A. Well, again, the same, that the individuals whom he felt had to be locked away because they were dangerous to Society on the one hand and, secondly, in danger and in need of protection from Society, that they were making out quite well in the community.

So I think we have to recognize that in the category of the center that is below the capacity of — inactivity day centers we have throughout the country, thousands of such people below the educable — [7-74] not below the educable levels, I want to emphasize that. I am not talking about that — walk the streets. Some of them use public transportation and we have had a minimum of problems about them, but thereby hangs, I think, an important tale, and that has something to do with what we have learned from Scandinavia.

When, as a result of President Kennedy's emphasis and his sort of mentioning of Scandinavia, a lot of our people interested in mental retardation came to Scandinavia and looked at the institutions and always asked to see the findings of the severely-retarded. They came back and said they never showed them to us.

The point is they couldn't recognize them. They had a haircut, they were decently dressed, and they ate with knives and forks and they lived in normal rooms.

I well remember one of the Scandinavian directors told me about an American gentleman from one of our institutions, and a very good person, who visited an institution, noticed a window, and he said well, these windows can be opened.

The Scandinavian man said yes.

But they can get out the window.

And the Danish fellow said yes, they can, but they usually use the door.

[7-75] You see, we have in our country not yet developed to understand the history of Danish architecture. We have got to realize that we really had a position which is reflected in the way the individuals were handled, that this was a deviant sort of pseudo-criminal group, if not active potentially criminal, which had to be restrained.

We always built our institutions like this. We built windows so high one couldn't look out.

What the danger was about them, and always with small little spaces there, with metal in between, and I had a very constructive experience. When I had come back to Massachusetts with some series of slides from Denmark and Sweden and I showed them at the Tunnel School, there were some of the older medical people there and some other staff and the doctors said well, nice, nice, but it would never do here because they would break the windows immediately; you ought to see how many windows we have broken.

And the matron spoke up and said well, she said, you know, the west window, which has a nice view, has never been broken — a tiny little observation, but it really had significance. This was a building — Terry Hall at Tunnel School — a maze of tile floors, tile walls, drains in the floor, which was in itself an incitement for rioting.

I have watched, Counsellor, in Connecticut a kind of a ward like this being transformed. New furniture was bought, flowerpots were put up and so
[7-76] on, just to show what they would do with this kind of thing; and nobody broke anything. Destructiveness decreased.

In Sweden we transferred a group of profoundly-regarded individuals — I am talking about that particular group now — from the typical old institutional situation to one where they lived in nor-

mal beds, had small rooms, carpeting on the floor and so on; and they measured the success in interesting ways.

They weighed the linen changes, they counted the number of changes in clothing; and they found that the people no longer would soil their beds, that they wouldn't soil themselves and require change of underwear and more than just underwear.

They literally proved that the behavior changed with the change of environment.

Q. Then your testimony is that all of the people at Pennhurst can live in small-scale places in the community?

A. Absolutely no question about it, with, of course, the qualification that some of those who need acute medical care, like the rest of us too, may have to spend some time in the hospital, obviously.

When I think of community care I mean living spaces such as we are using. For some of them it may be an apartment. For others it may be a community residence; and for others, a situation where
[7-77] they can get nursing attention and so on.

But the degree of impairment does not necessitate their remaining in an institution. As a matter of fact, I again point out it is harder for them to get adequate care in Pennhurst or all my Massachusetts institutions than if you live closer to the community where good medical attention is available on a much more informal and more normal basis.

Q. So that your testimony is that the residents in the community, living in small-scale facilities, make many things possible —

A. Yes.

Q. — for their growth and development and the rest?

A. Yes.

Q. Is anything further required in your opinion to assure that the possibility is realized?

A. Well, obviously, as the institution and the administrators, as its compactness, you have one superintendant you can hold responsible if anything goes wrong. You call him up and say, "Doc, what's going on?"

Obviously, if he disappeared into the community we need some new mechanisms, but some of them have already been developed. Monitoring is of the essence.

I remember very well Goldman — wasn't that the name of the Commissioner of Mental Retardation in Pennsylvania? — who wrote a strong memo-
[7-78] randum to his superior pointing out that the whole Pennsylvania program would be in jeopardy unless you put in place the proper monitoring.

Let me say, by the way, I am not just talking about watching that nothing untoward happens in those particular names. That, of course, we ultimately have to see — that the people who contract live up to what they contract for; but when I speak of monitoring I also think of somebody making sure that the plans worked out for certain individuals, which goes, of course, beyond the residence, are actually being carried through and this kind of monitoring is something quite different, you see.

Furthermore, I also feel — and as a State employee I have great respect for the State government. I have spent years in the State government, but nevertheless I like State government to have somebody to look over its shoulder, so I am not content with merely monitoring by State or the local government, since these are two separate levels, but I want the informal citizen system where this can be done by having a board to take care of this.

I also hope, of course, that we can establish, as, of course, more recent federal legislation is actually anticipating, an individual advocacy relationship for

people of a certain degree of handicapping condition, not the mental retardation.

Q. What are the functions of such a relationship?

[7-79] A. What are the functions? Well, of course, —

Q. Is this relationship commonly called the citizen advocacy?

A. This would be something like citizen advocacy, yes; and this may sound sometimes a little bit more formidable.

Citizen advocacy is a good term to use with a twenty-six-year-old retarded man. When it comes to a youngster I still call it, I mean the technical term is all right but it means somebody who knows the individual, knows his needs, and somehow has been informed what steps one can take, what mechanisms are available, because every state has mechanisms of appeal and requests and so on to make sure that the individual gets his needs fulfilled.

The kind of looking-after for a child, which, of course, normal parents would do, but I certainly agree that with the profoundly-handicapped child very often it may be beyond the parents' capacity to marshal all the forces that are needed to help.

Q. Do you know, sir, that eighty percent of the approximately 1,254 people who are at Pennhurst presently went there when they were aged five to twenty-one?

A. Yes.

Q. And that since 1971, when admissions were technically, theoretically closed, another 200 people have gone there, most of them children?

A. Yes.

[7-80] Q. Why is it that parents and relatives can consign people to institutions like Pennhurst?

A. I think parents very, very often have absolutely no choice. It is not a decision they make; it is a decision that is forced upon them to some extent by peo-

ple who are convinced such individuals ought to be segregated.

In other cases, because parents have asked for help and the problem, of course, gets worse, the management of a child who does not receive adequate supportive services, and the management of the family with the child who doesn't receive adequate supportive services is getting worse and worse until finally the parents reach the point where they need to make this decision. They think — I have always insisted that institutional waiting lists are not waiting lists for people who want to get into the institution, they are waiting lists for non-existing community services or for community services which don't exist in sufficient degree.

Q. And you get —

A. I think you will find they have made studies about this. You made a study in Pennsylvania and when you asked people on the waiting list what they really wanted, and those who, in spite of existing situations at institutions, were quite far down the list, I think, if I remember correctly, they were asking for community residences and for vocational work.

That's, of course, a problem for many of our
[7-81] parents of all the children now — they look beyond school, what will happen then.

They didn't ask for what was probably the most important thing that we could render, but how can they ask for something they really don't know that it could exist, and that is help to the home because if you have early help rendered the parents in the home then the management of the child becomes so much easier that a lot of the severe problems never develop.

* * *

[7-82] BY MR. GILHOOL:

Q. Dr. Dybwad, did you participate in the planning

of a community service program for residents of Pennhurst and others in Southeastern Pennsylvania in the late 1960s and early 1970s?

A. Yes, to some extent I did.

Q. Would you describe your participation?

A. My participation in Pennsylvania mental-retardation affairs goes back about twenty years, but with particular attention to the Pennhurst situation it probably coincided with the possible expose in 1965. It was coincidentally at that time that the comprehensive mental retardation plan for Pennsylvania was published, one of the first in the country, resulting from Kennedy legislation.

[7-83] I had served in the Kennedy administration as a consultant when this came about, so I was involved in this and again this mental-retardation plan, with a corresponding mental-health plan, resulted in the 1966 legislation of the Community Mental Health-Mental Retardation Act, which was one of the earliest of such acts, and really began to focus on alternatives to institutional care.

It was at that time that I volunteered my services to the Pennsylvania Association for Retarded Citizens as a consultant. I had established good contact with the leadership while I was the National Executive Director of the National Association for Retarded Children, so during those years I made very frequent visits.

I remember that I analyzed for them the regulations which were drafted over a long period of time with regard to the MH-MR Act of 1966, and then later in the sixties I testified before both the Como and McGraw committees of the State Legislature, and their report led to Act 256 in 1970 — now I come to the point — which made $21 million available for community facilities to free 960 Pennhurst residents and allow them to live in the community.

There were difficulties about this and I participated in meeting with the Governor and the Secretary of Welfare and then, in 1970 and '71, I assisted the then Commissioner of Mental Retardation with
[7-84] assembling a panel of thirty experts among the many architects with regard to the implementation of this Act 256 and to take a look at the statewide picture of institutional facilities.

I remember it was at that time that Architect Gray of New York, whom I had brought to Pennsylvania, presented a very useful statistical formula which showed at what point it was futile and financially unbearable to repair old institutional buildings.

Well, I think this was about the core of my activities.

Finally, your Honor, I worked closely with the Pennsylvania association in the preparation of the right-to-education suit, but I had to forego the pleasure of testifying. You cut off the testimony, but that was a very definite involvement with Pennsylvania, so I —

THE COURT: We didn't know what we were missing when we did that.

BY MR. GILHOOL:

Q. Dr. Dybwad, in your opinion could Pennsylvania have provided residences and services in the community for all of the people then and now still at Pennhurst many years ago?

A. Well, in 1971 I would venture to say there was no other state as well prepared to arrange for community placement of persons from the institutions as was Pennsylvania.

Q. Why is that?

[7-85] A. Well, first of all, it had, in comparison with many other states, a vastly better structure due to the 1966 legislation. It didn't have just the county of-

fices everywhere, but in addition it had organized Base Service Units — at least a system was set up of Base Service Units which really made for a potentially effective delivery system.

The problem is do you have a service delivery system. Pennsylvania, with its Base Service Units, had this method and it still has them to this day and then, of course, there was the office of the Commissioner of Mental Retardation.

The next, of course, was that they had $21 million — $21 million for the one and only purpose, not competing with any objective, of placing persons from Pennhurst — it was, of course, earmarked for Pennhurst as a result of this 1970 legislation.

The third one was another rather singular achievement of Pennsylvania, and that was the Phase I report written by Dr. McDowell. This is a very carefully-detailed report proposing ten prototypes of various community residences of various types for the more dependent, the less dependent, and so on, of which a prototype was not useful for Pennhurst because that could have been utilized for others in the State.

He had worked out, as part of his report, a system of dispersal across the five counties serving
[7-86] Pennhurst. He had worked out in detail the very difficult problem of supportive services such as vocational services, day services, and so on, once the people are placed in the community.

He had costed it out and, remarkably, for once he didn't say there was enough money, but he costed all of this out as costing $17 million of the $21 million.

He had detailed implementation steps and, as I say, it was really a unique achievement because it was a blueprint. It wasn't just a vision of somebody; it was a very detailed cookbook as to how to proceed; and no other state has this.

Q. And by what date was that blueprint, as you put it, completed?

A. Oh, that was 1971. The money was allocated — 256 was in 1970 and his report was submitted in 1971, it was printed.

MR. GILHOOL: Your Honor, that report appears at PARC Exhibit Number 24.

BY MR. GILHOOL:

Q. Dr. Dybwad, today, in 1977, has it happened? Have services in the community been provided? Has Pennhurst been displaced or obviated?

A. Well, Pennhurst still has more than 1,200 people. Only twenty residents of Pennhurst, if I am correctly informed, have really benefited from the Act 256. I think they are still residing there but they
[7-87] participate in some services under the act.

Q. And the basis of you information there is the deposition of Catherine Clark, Director of the Social Services Department at Pennhurst, and the deposition of Mel Knowlton?

A. Yes.

Q. That's a question.

A. Yes. Well, I know about this.

Now the population has decreased, of course, but 151, I think, live in CLAs, what is known as the Community Living Arrangement units, and four times as many left Pennhurst and went to other institutions — 342 to Embreeville, which was a made-over facility for the mentally-ill; 96 to Woodhaven; 31 to other State schools and 112 to Pine Hill Central, which is sort of a traditional nursing home in Philadelphia.

I had something to do with it. At hearings I visited the place and it is just a nursing home.

So that four times as many went to these places and essentially they went from one frying pan into another frying pan and the fact that the second

frying pan had Teflon lining didn't particularly make it easier for the person being fried.

It was just from one system to the other so the answer is obvious — the twenty-one million and the plan which offered a tremendous promise has not been fulfilled.

Q. Why, in your opinion, has it not happened?
[7-88] Why, despite the Phase I report and the other matters that you spoke of, have community services still not been provided so as to displace Pennhurst?

A. Well, the people who are involved in public life — they say "Why?"

Questions are often very, very important. We get good legislation. Why is it not being realized?

We have money allocated; why isn't it realized?

In 1969 the President's Committee on Mental Retardation published a report entitled "Changing Panels of Residential Care" and in a concluding chapter I addressed myself to this "why" — what are the obstacles to change — and I think they fit the situation, if I may recite them.

The first is the bureaucratic inertia. Bureaucracy doesn't have a habit of moving and very often what you are getting is really a bureaucratic subversion of a declared public policy.

The State of Pennsylvania, both through the Governor, through the Legislature, declared the policy but the bureaucracy failed to carry it through and in this particular case it is so different because the money was there; that was not the excuse.

The second one is that even if bureaucrats want to move you have what the sociologists call system maintenance. It is just the momentum of
[7-89] the current service pattern that just goes on and on and it is very hard to cut in with something new because the old one rolls along and everybody is geared to this.

The third point is a very serious one, and that is, of course, the staff's concern with job status, job security, and job opportunities. It is a very well-founded concern, but nothing new.

We have in many areas in public life and in industry had to find new jobs for people and apply to the government for funds for this and a planning pattern for this, but nothing was done about this.

I think another point is in our field the insufficient regard for the very clear fact that persons with mental retardation have a capacity to make it in the community. There is still a lack of belief in this and, obviously, public officials lacking such an attitude will not be motivated to proceed. They will continue traditional prejudice, will not exert themselves, and they lay.

I really can't find other answers because you have this very strange situation of these veritable circumstances. I, as a former state official, envied Pennsylvania in the early 1970s. I still don't quite know whatever made the legislature so generous as to allocate $21 million, but they did, so it is very hard to think well now, if I want to be a little more
[7-90] specific about this last query of yours, because a program as ambitious as that, that was laid out in 1970-71 and '72, needs a manager.

You see, it involves quite a number of levels of government, quite a number of departments. It dealt with quite different things that would involve zoning ordinances, fire-safety regulations and so on.

There should have been a manager, a coordinator. You always talk about quarterbacks. I don't know what it is, but something like this was needed and from very frustrating meetings, and I still have in my files piles and piles of memoranda, it was very clear that there was no one with the primary responsibility to build up a program, to make sure that it be carried out.

Instead of that ability being just diffused, it was confused. You just couldn't pinpoint things, so between the county officers and the Base Service Units and the regional offices, which in those days were as yet getting organized, and which had as yet a questionable role, the Deputy Secretary for Mental Retardation, who presumably only had a staff function, the Deputy Secretary who carried all the field functions, the secretary herself, the state fiscal office, and the various administrative officers had their concerns — their just was no cohesion.

Let me give you an example. I remember Base Service Units were given the task to propose for
[7-91] each resident of Pennhurst a life-management plan. It was a very sound idea. After all, these people belonged someplace, they didn't belong to Pennhurst, so the Base Service Unit offered this plan to be sure that when they were ready to come back, when they were coming back, there was somebody who knew about this.

Well, they didn't do it, but whose job was it to enforce it? Who, really — through what channels should this have been pursued?

When, in Act 256, service facilities were open but they failed to assign places to Pennhurst residents, whose responsibility is it?

I mean this was the situation. I spoke of the first phase plan, which was very detailed, a marvelous document; but, of course, it was not yet translated into administrative steps, obviously not.

The person who wrote this report was an outsider, so whose problem really was it to make sure that this was translated and scheduled and deadlines and closeouts and allocations and so on; and whose job was it to really tackle it?

Obviously, it wouldn't just be Pennhurst; it would happen in other institutions. There was the problem of job security to assure the unions and

their membership you will not be foresaken, somebody is going to look after you. You serve the public, you have a right.

[7-92] None of that was done. I think here are some examples of what caused the problem.

Q. Did the officials with whom you worked in 1969 through 1971 know that these steps, these things you have mentioned, had to be done if community services for Pennhurst residents were to be a reality?

A. Oh, goodness, yes, of course.

In many cases, you see, I made reference to one memorandum earlier today of Commissioner Goldman. It just was in my mind because it was written with such unusual clarity and useful to this day by pointing out the need for monitoring and so on.

No, there were memoranda, both from within the administration and, of course, from PARC, from the Pennsylvania Association for Retarded Citizens, in which these things were spelled out and, as I said, we attended meetings in the Governor's office, in the Secretary's office, where I think, yes, the knowledge was there.

Q. Finally, did the State and county institutional officials have, as early as 1969 through 1971, the early seventies, the funds to do it?

A. Well, as of 1970 I address my question because 256, again, I say, was unusual because it was not the kind of appropriation we get in Massachusetts, where, with great public fanfare we are promised $6

[7-93] million and by the end of the fiscal year the funding has been used for something totally different, you see.

This was set aside. This was a fund, it was not an annual appropriation; so, yes, the funds were available, certainly.

In addition you, of course, had the base allocations, you had the institutional budget which you can't disregard, which also could have been utilized for this, and you had the plan, I would think, so that the answer to that would be yes.

* * *

CROSS EXAMINATION

* * *

BY MR. WATKINS:

Q. Dr. Dybwad, do you know whether those funds still exist or have they lapsed in your view?

A. No, these funds still exist, I think. I am not a Pennsylvania citizen.

I think I heard that something like $15 million is still in that account, but to the best of my knowledge these funds still exist, they continue to be earmarked.

Q. How many institutions do you have in Massa-
[7-94] chusetts of the Pennhurst nature, if any?

A. Oh, as far as I am concerned, I would put all five in the same category, even though each individual superintendent would feel that he had done something this or that that would raise him a notch above it.

I think in all fairness that they compare with Pennhurst.

* * *

BY MR. SACHS:

Q. The last question that was presented to you on direct was talking about the funds of $21 million.

Did the State and county have the funds to do it; and your answer was yes, the funds were still available?

A. Yes.

Q. To your knowledge, do you know if Philadelphia County or the other four counties in this southeastern region got any of the funds at all?
A. No. All I know is —
Q. No, you don't know, or no, they didn't get the funds?
[7-95] A. I don't know because, you see, I, for instance, would not know the procedure under which these funds would be disbursed because the question of getting funds, you see — $21 million was set aside. Philadelphia has several base units, you see. Now it would have access to this money that was allocated from the State legislature, but, obviously, I don't know through what channels the Base Service Units in Philadelphia would have to go to get the money. That I just don't know, I'm sorry.
Q. On cross examination by Mr. Watkins he asked you if you knew if these funds still existed and you said something to the effect — I heard $15 million still existed.

So, therefore, to the best of your knowledge, something in the neighborhood of six million has been spent and fifteen million are still around somewhere?
A. To the best of the knowledge of a person who is vitally interested in Pennsylvania, because I am from Massachusetts, to my limited knowledge, yes. To the best of my knowledge some of that money is still available and my recollection is that it is $15 million. I am sure that was the figure.
Q. One last question I would like to ask you:

Do you know if Philadelphia County or the other four counties would be able to start up a program to carry out the community living arrangements with their own financial resources or do you believe they would have to depend upon the State to implement this type of program?

[7-96] Can they do it on their own without State aid?
A. Well, you are speaking now not of the 256 funds.
Q. No, I am talking about any kind of State money including the 256 funds. I am asking your opinion.
A. Yes.
Q. Can any one of the five counties start up and implement or make the necessary arrangements without State aid?
A. The legislature didn't seem to think so or else they wouldn't have made the State appropriation.

* * *

REDIRECT EXAMINATION

By MR. GILHOOL:
Q. Dr. Dybwad, have you had occasion to read PARC Exhibit Number 60, a report dated in the fall of 1976, a status report as of that date of the Act 256 project?
A. I have seen it once. I am afraid you will have to refresh my memory, Counsel.
[7-97] Q. I show you a copy of PARC Exhibit 60.
A. Yes.
Q. That report shows, does it not, the continuing availability of those Act 256 funds as you have testified?
A. Yes.
Q. Have you had occasion, Dr. Dybwad, recently to read PARC Exhibit Number 58?
A. It says sixteen million and not fifteen.
Q. Yes.
A. I am sorry.

BY THE COURT:
Q. Did you say sixteen million or fifteen million?
A. Now wait a minute. No. Wait a minute, this is DES funds, I am sorry.

BY MR. GILHOOL:

Q. Exactly, but the name of this project has been called in recent years DES instead of 256. It is the same act.

MR. WATKINS: Are you referring to that?

MR. GILHOOL: I think we will stipulate to that.

MR. WATKINS: I will stipulate that the funds are still available.

MR. GILHOOL: Exactly.

BY MR. GILHOOL:

Q. With respect to PARC Exhibit 58?

[7-98] A. Yes, this was —

THE COURT: It was stipulated to how much?

MR. WATKINS: I am not certain. It is somewhere in the neighborhood of fifteen to eighteen million, I believe. I am not certain.

MR. GILHOOL: The report in the exhibit will show the figure precisely.

MR. WATKINS: Yes. We have the same report.

BY MR. GILHOOL:

Q. With respect to PARC Exhibit 58 —

A. 58? Yes?

Q. — which is entitled "CARRYOVER, COUNTY MH-MR PROGRAM FISCAL 75-76," have you had an opportunity to review and read that report, PARC Exhibit 58?

A. Well, it shows region by region for the State that there are carryovers, which I interpret to mean unexpended funds.

Q. And it shows for the fiscal years '72 through '75 some $5,600,000 allocated to the five-county region?

A. Yes.

Q. For community services which are unspent and returned to the State; is that correct?

A. Yes, county by county, right.

* * *

Testimony of J. C. Hirst

[7-101]BY MR. PEABODY:

Q. Dr. Hirst, where are you employed?

A. Pennhurst Center, Spring City, Pennsylvania.

Q. And what is your position at Pennhurst?

A. I am the Director of Psychological Services.

Q. And how long have you held that position?

A. Since 1965.

Q. Could you outline for us, if you had prior employment at Pennhurst, the various positions that you have held throughout the years?

A. Going back, I was with the State Civil Service Commission, and as the acting director of such instruction, I was associate professor at Ursinus College, Collegeville, Pennsylvania. That was my terminal position.

I worked in industry as an electrician's helper, I worked for the Penn-Central Railroad in various laboring jobs, I worked at Purdue University as a direct teaching research assistant, and I worked for the Pennsylvania State University for nine years as a continuing education instructor.

Those were my major occupations and there were other short terms in between.

Q. Could you outline the positions that you held at Pennhurst prior to becoming chief psychologist?

[7-102] A. I came to Pennhurst full time in 1958 as what they call the ward or cottage psychiatrist. This is a general clinical assignment.

Two or three months after — in those days I was designated the Chief of Vocational Services, which at that time was in the Department of Psychology, and provided the vocational service for the institution, utilizing our resident help and training them.

After that I became the Assistant Director of the Psychology Department for a number of years

and finally there was a vacancy in 1965 and I was promoted as the director and remained there and am still.

Q. So you have worked at Pennhurst for about nineteen years?

A. Close to nineteen years.

Q. Could you outline for us your education, beginning with college?

A. I attended Franklin and Marshall College in Lancaster, Pennsylvania, and graduated with a Bachelor of Science degree;

Purdue University, which is at Lafayette, Indiana, a Masters degree in Clinical Psychology; and

Temple University, Philadelphia, in 1955, with a Ph.D.

Q. Ph.D. in Psychology?

A. Yes, sir.

Q. What are your present duties at Pennhurst?

[7-103] A. I am the Director of Psychological Services and operate that department, with general management and supervision of meetings in terms of psych service.

I am also the institution's first chief consultant to the [Human Rights] Committee.

Q. Do you supervise the various psychologists on your staff?

A. I do, both directly and more desirably by having middle line supervisors.

* * *

[7-106] Q. Are there presently residents at Pennhurst which are not receiving psychological services which they are in need of?

A. In my opinion there are many residents not receiving psychological services that they need urgently.

Q. And when you say "many", how many are you referring to?
A. I would say hundreds.
Q. Hundreds?
A. Yes, sir.
Q. And when you say that they are in need of the services urgently —
A. I said urgently, yes, sir.
Q. — what did you mean by "urgently"?
A. Because time moves by. Many of these residents have been there a long time. Many of them are engaged in a struggle coping with the environment, coping with their plight; and psychological service, to be valuable, most often has to be very direct and closely interfaced with the client, one-to-one most desirable, and it is just impossible to provide that
[7-107] type of thing for all of these people that live practically under one roof. It is impossible to do it.
Q. What are the consequences for the residents at Pennhurst who are not receiving psychological services which they urgently need?
A. I think it presents a deprivation, a crippling situation, although I would mention that many of these that aren't being seen by psychologists are probably receiving other services from other disciplines, but even so —

* * *

[7-116]BY MR. PEABODY:
Q. From your observations, Dr. Hirst, have you seen residents regress or lose skills?
[7-117] A. In my opinion, I have seen residents lose skills to a degree.
Q. From your observations then and your experience in dealing with such persons, what are the major reasons for this regression or loss of skills?
A. I think there are a number of reasons. Chief

among the ones that I dwell on when I see this happen, first is what I call the motivational reason. Many of these people have been there so long that they have given up hope; and if you give up hope and drive and motivation to do different things and to go different places or to take on a different image, as the hope dwindles so does the energy.

Then there is just a sort of a quietness that overcomes a person and they'd rather not attend the workshop, they'd rather not have the counsellor talk to them about outside placement, but would want to stay at Pennhurst.

And by regression, too, as they regress, as they stop their motivation and their activity level, you see a diminution of skills.

Q. From your observations and your experience in dealing with such residents do you know of reasons why the residents have lost motivation and have become filled with quiescence, as you put it?

A. There are probably many reasons there too, but
[7-118] paramount among the one that I focus on is the nature of the environment, the environment contribution to despondency.

Q. Could you describe for us what it is about the nature of the environment which leads to this despondency, as you put it?

A. Well, my opinion is that the environment is deprived, and by "deprived" I mean it is isolate. Even though it is right next door to a community it is still Pennhurst. It has a wide perimeter of grounds around it and it is a segregated facility.

Only retarded people reside there and a few staff do reside on the grounds, and then some fifteen hundred people come in to work. That's the extent of your integration and the people who come in to work are teachers and trainers and that kind of thing, but very few peers come in.

Another thing about the environment is the physical design of the place. Many of the buildings are two stories high. People are living upstairs, some of them very fragile physically, and many of them kept up there for years and they reach a point where they'd rather not go downstairs.

Then there is the sociological part of the physical design — thirty to forty to fifty people on a cottage. That's too big a family constellation for a person to operate in to be personalized at all or to have personal relationships with the parent figure.

Furthermore, the environment, in my opinion taken from observations, does promote a crippling
[7-119] effect on behavior, education, and attitude.

Q. Are there specific things that you have in mind about the environment, things you have observed which contribute specifically to these conditions you described?

A. Yes. The physical design of some of the cottages and wards. They are so designed that they create blind spots and it is difficult for the aides to supervise these large numbers of people.

Secondly, many of the residents in the cottages are confined for long periods of time, and we all know what confinement does to a human being. It breeds aggression, and aggressions result in acting out, and acting out is contagious. People hit one another and when a person gets hit he hits back.

Then you have this long series of what we call accidents, which in my opinion are not really accidents. They are constants of the environment, the battle of a person fighting back, and I think most of them are products of the environment rather than any particular disability.

Q. The environment then is causing the aggressive behavior?

A. Right.

Q. And accidents of various kinds?
A. I believe that to a large extent.
MR. GOLDBERG: Objection, your Honor. I be-
[7-120] lieve he is now in the realm of opinion testimony.

BY MR. PEABODY:
Q. In your work, Dr. Hirst, have you become acquainted with the principle of normalization?
A. Yes, I have.
Q. And have you become an adherent of that principle?
A. I adhere to that policy or principle or ideal. I believe it works.
Q. Can you describe for us what it means to you?
A. Normalization in terms of handicapped people simply means to me that if you desire to have a handicapped person develop and reach the point of, say, the average of society, then you must give him experiences and environment and opportunity such as the average person in the society that we are having him meet, their base line.

So in a nutshell a normalization means to become normal you must have a normal experience in life environmentally, familywise, culturally, educationally. You must at least have the opportunity.

It is unfair to expect handicapped people to achieve what we did when we did not give them the opportunity to be counseled like we have.
Q. From your observations and your experience at Pennhurst can the environment at Pennhurst presently provide a place to implement these principles?

* * *

[7-124] BY MR. PEABODY:
Q. Dr. Hirst, what observations have you made at Pennhurst regarding the possibility of implementing the normalization principle which you have described for us?

A. I observe an environment that is not conducive to normalization.
Q. And what have you observed that is not conducive, specifically?
A. Because the environment is untypical of our society. It segregated, it is isolate, it is group living versus family living.
Q. And by group living what do you mean?
A. People living together in very close physical and psychological contact in large wards, sleeping dormitory style, incarceration and inhumane confinement in that building.
[8-109] Q. You used the word "incarceration" with reference to that building.

Is the situation there worse than for other buildings?
A. I think the New Horizons building is the worst area in the institution.
Q. I believe I recall Gunnar Dybwad talking about it.

What's the nature of the worst building? I thought it was one of the newer buildings.
A. It is a new and very expensive, architecturally-clean building, safe and bombproof; but, as Dr. Dybwad pointed out, better than I can, it is no place for habitation, for people to live. There are blind spots in the ward. It is a high-rise building with elevators and the only steps inside being fire exits.
Q. Are there people who are incarcerated there without the opportunity for outside recreation?
A. Absolutely.
Q. What proportion?
A. I won't say that nobody goes out.
Q. What proportion of people, based on your observation, get to have daily recreation outside?
A. Out of the six wards, I would say one or two at the most, and for a very limited time.

[8-110] Q. One or two wards or one or two people?
A. During weather like we are having now, one or two wards, maybe after supper or out for a period in the morning; but it is even difficult there because the play areas, the recreation areas, are benches. There are some benches there and some swings and sliding-boards.

But you must remember we have adults in that building who might want to be beyond the sliding-board age and the seesaw.
Q. No recreational facilities for the adults in the building?
A. There is a swimming pool in the basement and there is a gymnasium.
Q. Nothing else?
A. Well, the two playgrounds, you know, which I regard as simply large cages. There are no trees. There is not a water fountain, there is not a toilet.

It is very inconvenient to take them there and I have compassion for the aides who try to do that.
Q. So the aides would be deterred from doing that because of the difficulties?
A. The realities of the difficulties; right.
Q. Have you contacted any official higher than Dr. Youngberg regarding your complaints?
A. I have talked to several high-ranking State officials in the last few years.

[8-111] Q. Who are they?
A. Going back quite a bit, even before Dr. Youngberg and Dr. Smilovitz came on the scene with us and before New Horizons opened, I talked with Dr. Donald Jolley, who was the Commissioner of Mental Retardation for the Commonwealth.
Q. How about since Dr. Youngberg?
A. I have talked with Mrs. Irene Pernsley, who is the ex-Deputy Secretary of Welfare for Region I here in Philadelphia about my concern for the plight

of the residents at Pennhurst and the condition of the institution.

Mrs. Pernsley generously granted me three and a half hours to chat with her.

Q. Do you know if she communicated any of those concerns to Helene Wohlgemuth, Secretary of Welfare?

A. I don't know. I certainly hope she did.

Q. Did you ever speak to Helene Wohlgemuth about that?

A. I did.

Q. And that was briefly at Pennhurst?

A. I spoke with her briefly at Pennhurst when she visited the modular community, and I —

Q. Did you ever speak with Mr. Beal, Frank Beal, about it?

A. I never spoke with Mr. Beal. I have written letters on behalf of advocacy groups and myself to Mr. Beal.

Q. And has he responded?

A. I never saw the answers come back from him.

[8-112] They came back from subordinates of Mr. Beal.

Q. Do you know if Mr. Beal has visited Pennhurst?

A. He has visited Pennhurst, I think, on one or two occasions, but I have never seen him.

Q. Any other officials?

A. Mr. Stanley Myers. He addressed one evening a "Plans for Pennhurst" meeting and Mrs. Valaida Walker, who was his deputy, I think, for the region. I spoke to both of them and addressed them asking them if they recognized the emergency that we had at Pennhurst.

Q. What did they say?

A. Yes, we do.

Q. Why do you consider it an emergency?

A. I consider it an emergency because of, you know, the whole battery of things that we have all

been testifying to. The residents at Pennhurst have a plight that must be advocated because they are in the situation.

We try to get them to improve, to get them in the modular homes to give them a place to live before they go to the community, to give the community time for a group of homes; and then the Commonwealth turned down the plan for Pennhurst and the net result is that the residents wind up in the substandard areas of changing environment, which is worse than they end up with in some ways.

[8-113] Q. Dr. Hirst, based on your experience in attempting to change Pennhurst and meet the plight of its residents, are you satisfied with the progress the Department of Public Welfare has made in, let's say, the past few years? Are you satisfied that that progress will result in what will be best for the resident?

A. I won't say that there have not been sincere efforts and I will not say that there have not been sincere efforts and concern coming out of the Department of Public Welfare.

I am cognizant that the system moves slowly, but I really believe that the plight of the residents at Pennhurst cannot be moved by the present actions of the system I have observed, unless in concert with those actions there as an individual and group advocacy for each resident that is unfortunate enough to have to be at Pennhurst.

* * *

[8-114] A. I couldn't get Freddie or participate in the admission of any retarded son at Pennhurst Center for the simple reason, not that there aren't kind people there that would try to help him and love him; but because his destiny, if he were admitted to Pennhurst his destiny would not be defined to me

and Mrs. Hirst as to where he might be thirty days from now or thirty years from now.

Under the present plan he could be in Pennhurst until the year 2000.

Q. How would you characterize his destiny at Pennhurst?

A. With the present dilemma in terms of programming and life management and what the agencies are going to do and how they are going to get together to reshape and resolve the plight of Pennhurst residents, I am sorry and regret it because I am part of Pennhurst.

I regret to have to say that I think his life, his lifeline and his time-line would be haphazard.

* * *

[8-119]BY MR. WATKINS:

Q. Doctor, are you aware of any residents who have had beneficial programs terminated for reasons of punishment; and you can define "punishment" before you answer the question.

A. Punishment, as we use it in the profession and in our operational work usually means the withholding of some pleasant thing or a reward as a result of an activity or the lack of activity on the part of the person. That's punishment.

If you are not good you won't go to the movies. That's the removal of a pleasant thing.

I think what I said, and I am willing to stand up for everything I said, but recollecting back I said that I was against the deferment or the denial of programs for atypical behaviors and that I thought that kind of thing was punitive on the part of the institutional system that imposed that on a person. I think if you punish people for a reason like that, that isn't the resident's fault, you deprive him of a full range of programs because of behavior that isn't just right.

[8-120] Q. Let me ask you —

A. You know, as far as getting a list of case numbers, I am willing to cooperate with the Court but I can make it a lot easier than that and go on record as saying many of the residents of the New Horizons Building I place in this class; in fact, most of them.

Q. All right.

Most of the residents in the New Horizons Building, in your opinion — I just want to make sure we are talking about the same thing — have had therapeutic programs deferred or terminated —

A. I won't say that; I will say not initiated.

Q. All right.

A. Because of the demand.

Q. I am well aware of that.

MR. FERLEGER: May the question be answered, please?

THE COURT: Go ahead, Doctor. You may finish.

THE WITNESS: Because the demand — you know, the word is interesting and we are both guilty, I guess. Deferment, withholding, and not finishing, you know, to me are all three equal.

BY MR. WATKINS:

Q. I am asking you about deferring and withholding.

A. I think a lot of the programs for New Horizons
[8-121] residents have been denied, deferred, withheld because of the nature of their hyperactive, atypical behaviors, much of which is consequent to the residence they live in.

That is a conviction I have and I am not saying whether I know all the answers on it, but that's a conviction I have.

Q. When was the last time you reviewed the annual program reviews for the residents of the New Horizons Building?
A. I have not reviewed those.
Q. When was the last time you got an assignment or an inventory of the programs that are being offered to the residents of the New Horizons Building?
A. I get a picture of that about every day, Mr. Watkins. I have two psychologists working upstairs.

I get the psychs, I get the treatment plans, I have verbal conversations with those people and I am up there on those frequent occasions. It is right upstairs.

There are visitors that come in the New Horizons Building that want to see this new building.

I can tell you what the programs are up there. They are self-help programs. They are very limited programs that have been going on for years.

The outreach programs from that building are very lean and far between, and small group activity, other than the foster grandparents who can only take a handful at a time because of the fragile nature of these residents.

* * *

[8-122] Other than that I don't believe any of them have a comprehensive program.

* * *

Q. Do you know of any residents in the New Horizons Building or anyone that had a beneficial program that was at a time existing and has had that program terminated as a means of punishment and

* * *

[8-123] A. I said there is no individual at Pennhurst that I know that is punishing anyone purposely, maliciously, even designing punishment.

But there are conditions and circumstances for which we are all responsible that I feel are punitive, punitive to the class of residents at Pennhurst.

* * *

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[8-4]

Testimony of Robert Troester

* * *

BY MR. STUTMAN:

Q. Mr. Troester, did you ever live at Pennhurst?

A. Yes, I did.

* * *

[8-11] MR. STUTMAN: May I approach the witness, your Honor?

THE COURT: You may.

(Wrist restraint was marked PARC Exhibit 73 for identification)

BY MR. STUTMAN:

Q. I am holding up what has been marked PARC Exhibit 73. Have you ever seen this before?

A. Yes, I did.

Q. Have you ever seen an object like this that was bigger than this?

A. Yes, sir.

Q. What is this, Mr. Troester?

A. It is something like a straitjacket.

Q. Do you know what it was used for?

A. They used to put it around the boys, over their necks. Sometimes they would tie them behind their backs.

Q. Would they be standing up or sitting down?

A. Sitting down.

Q. Have you ever seen anyone in something like this —

A. I did.

Q. — when you were at Pennhurst?

A. Yes, sir.

[8-12] Q. Did you ever seen anyone in a larger one of these?

A. Yes, sir.
Q. Why do you think people were put in those?
A. They was bad.
Q. Do you know what a seclusion room is?
A. I do.
Q. What is it?
A. It is to put boys in.
Q. Where do you live now?
A. Doylestown.
Q. When did you move there?
A. Two weeks — I think it was two weeks ago, on my mother's birthday, I got out, out of school.
Q. Would it be a couple of years ago that you moved there?
A. Yes, sir.
Q. And did you ever want to leave Pennhurst?
A. Yes, sir.
Q. Did you want to leave Pennhurst for a long time?
A. Yes, sir.
Q. Did you tell anybody there that you wanted to leave?
A. Yes, sir, I did.
Q. What happened?
A. They told me to wait a while.
Q. And did they tell you why you had to wait?
A. No, sir.
[8-13] Q. One day they said you could go?
A. Yes, sir.
Q. And was that day your mother's birthday?
A. Yes, sir.
Q. In Doylestown do you live in a home?
A. Yes, sir.
Q. How many other men live there with you?
A. Seven men.
Q. Is there any staff?
A. Maxine, Walt — more staff is there, working there now.

Q. Maxine and Walter are there all the time?
A. Yes, sir.
Q. And other staff come when Maxine and Walt have days off?
A. Yes, sir.
Q. Does the door to that house have a lock? Is there a lock on the door?
A. Yes, sir.
Q. Do you have a key to that lock?
A. Yes, sir, I do have a key.
Q. When you come in the front door what does the house look like? Is there a living room?
A. A living room.
Q. What other rooms are there?
A. A dormitory.
Q. Are they upstairs?
A. Yes, sir.
Q. And that's where the men sleep?
[8-14] A. Yes, sir.
Q. Now you said dormitory. Is it like the dormitory at Pennhurst?
A. No, sir.
Q. How is it different?
A. I mean it is better.
Q. I'm sorry. Go ahead.
A. It is better there.
Q. Are there separate rooms?
A. Separate rooms.
Q. How many men sleep in the room where you sleep?
A. Just by myself, sir.
Q. You have your own room?
A. Yes, sir.
Q. Do you have a bureau where you can store your personal belongings?
A. Yes, sir.
Q. Is there a closet where you can put your clothes?
A. Yes, sir.

Q. Is there a bathroom there?
A. Yes, sir.
Q. How many showers are in the bathroom?
A. One.
[8-15] Q. Is there a shower curtain?
A. There is a shower curtain.
Q. When you go in the bathroom in the morning are other men in there with you?
A. No, sir.
Q. Do you have privacy in the bathroom?
A. Yes, sir.
Q. When you are in the house and the other men are there and you want to be alone, where do you go?
A. Upstairs.
Q. To your room?
A. Yes, sir.
Q. Who does the cooking in the home?
A. The boys do it; sometimes Maxine helps us out. She is a big help.
Q. Do you cook sometimes?
A. Yes, I do.
Q. Where did you learn to cook?
A. Food, and she helps me. Maxine helps me out, she gives a hand.
Q. And who cleans up?
A. The boys do, but I am trying — they don't let me clean up. I just wash dishes for the weekend.
Q. Who shops for the food?
A. Maxine does; we help her out.
[8-16] Q. Do you go to the local supermarket in Doylestown and buy food together?
A. Yes, sir.
Q. Is the food good?
A. Yes, sir.
Q. Where do you work? Do you work?
A. Yes, I work.
Q. Where do you work?

A. Doylestown some time. Now I am working in Ivyland.
Q. In Ivyland?
A. Yes, sir.
Q. Is that the workshop?
A. Yes, sir.
Q. How do you get from Doylestown, your home, to Ivyland?
A. By bus.
Q. That workshop that's in Ivyland is a new one, isn't it?
A. Yes, sir.
Q. Wasn't there the old one in Doylestown?
A. No, sir.
Q. Do you like the Ivyland workshop?
A. No, sir; too far from the house.
Q. Would you rather be able to walk to work?
A. Yes, sir.
Q. Did you used to be able to walk to work?
A. Yes.
[8-17] Q. And then they moved the workshop?
A. They moved it up in Ivyland.
Q. Strike that.
A. That's all right.
Q. What is your job in Ivyland at the workshop? What do you do there?
A. I usually do collating.
Q. Collating?
A. Yes, sir.
Q. And do you get paid for that work?
A. Yes, sir.
Q. How much do you get paid, do you remember? How much do you get paid?
A. Five dollars, sometimes more.
Q. It is different one week from the next?
A. Yes, sir.
Q. And where do you spend that money?
A. In the stores.

Q. In Doylestown?
A. Yes, sir.
Q. Do you go to the movies?
A. I didn't hear you.
Q. Do you go to the movies?
A. Yes, sir.
Q. In Doylestown?
[8-18] A. (There was no response.)
Q. Do you go to restaurants?
A. Yes, sir.
Q. Do you and the other men go to restaurants and to the movies when you want to?
A. I go by myself. I like to be alone sometimes.
Q. Do you work on Saturday and Sunday?
A. No, sir.
Q. What do you do on a Saturday and Sunday in Doylestown?
A. Well, I get up — I stay in bed on Saturday. On Saturday mornings I clean, clean the house out.
We all pitch in and help to clean the place up.
Q. Did you clean up in Pennhurst when you were there?
A. We never did, sir.
Q. Were there other people to do that?
A. No, never did.
Q. Do you like your home in Doylestown?
A. Yes, sir.
Q. Would you like to live there for a long, long time?
A. No, sir.
Q. Where would you like to live?
A. Apartment.
Q. In an apartment?
A. Yes, sir.
Q. With fewer people?
A. Fewer people.

* * *

CROSS EXAMINATION

[8-19] BY MR. FERLEGER:

Q. Hi. My name is David Ferleger. I am a lawyer for some of the people in this case.

How old are you?

A. Nineteen.

Q. How old?

A. Going on nineteen.

Q. And do you know how to read?

A. Not so good.

Q. What kind of things do you read?

A. I don't read sometimes.

Q. Did you like living in Pennhurst?

A. No, sir.

Q. Will you tell me why?

A. There's too many fights, too many arguments, too many stealings going on and all that, robberies, undesired things, and I'd change around.

I used to do bad things too, but now I changed myself. I am a different kind of man now.

* * *

[8-22] **Testimony of R. Hill**

MR. LASKI: Your Honor, the Pennsylvania Association for Retarded Citizens calls Mr. Robert Hill.

ROBERT HILL, having been duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. LASKI:

Q. Mr. Hill, where do you live?

A. 336 North Street, Chester.

Q. Did you live at Pennhurst?

A. Yes.

Q. What date did you leave Pennhurst?

A. April 15, 1971.

Q. In what building did you live when you were at Pennhurst?

A. L-3.

Q. Did other men live in the building?

A. Yes. It was more men than that.

Q. Was there more than one floor in L building?

A. They'd use the bottom of the canteen and there was a second L-2, and I was on the third floor.

Q. Do you remember what L-2 was like?

A. It was like one big room with forty in them.

Q. Did you work at Pennhurst?

A. Yes, I worked at Pennhurst.

Q. What was your job?

[8-23] A. In the greenhouse.

Q. Tell me about your job.

A. I would take care of the flowers, and run the flower beds and bring in dirt and fill up the flower pots and things like that.

Q. Was it pretty hard work?

A. No, not for me.

Q. Did you work every day?

A. Except Sundays up there at the greenhouse.

Saturday and Sunday I didn't work at the greenhouse.

Q. Did you do other jobs at Pennhurst?

A. I quit around three and take a shower and take a little walk until supper time. After I eat I go up to the blind to help them out.

Q. What kind of things did you do for the blind?

A. I'd wash the dishes up there, scrub the walls and the like, give them a shower, something like that, and take down the dirty laundry for them.

Q. This was after you finished work at the greenhouse?

A. Yes, after I come back and take a shower and eat supper I worked.

Q. Did you get paid any money for your work at the greenhouse?

A. No, I didn't get nothing.

Q. Did you get paid any money for working on the blind ward?

A. Oh, yes. The attendants would give me a couple
[8-24] of dollars for doing the work.

Q. They would give you a couple of dollars for working on the blind ward?

A. Yes.

Q. Did the staff give you medicine when you were at Pennhurst?

A. Yes, they give me medicine.

Q. Do you know for what reason they gave you medicine?

A. I have Parkin's disease, what they say, Parkin's disease.

Q. Do you take medicine now?

A. No, I don't take it no more.

Q. Have you been to the doctor since you left Pennhurst?

A. Yes, I have been to Crozer Hospital, the doctors.

Q. Did the doctor tell you whether you had Parkin's disease?

A. No, they didn't find it. No, they couldn't find nothing.

* * *

BY MR. LASKI:

Q. Tell me about the food and meals at Pennhurst:

A. Oh, the oatmeal would be kind of cold with a little sugar in it. Then we had toast and tea or something and toast, but some time I wouldn't eat it half the time in the morning, I wouldn't.

Q. Were you the only one who didn't eat it?

[8-25] A. Oh, I wasn't the only one.

Q. Did some other men —

A. There were some men that wouldn't eat half the food, they wouldn't.

Q. What did you do to keep from going hungry during the day?

A. Oh, in the morning, they had toast, it was just cereal or something else they had; but for lunch the food would be bad and I'd go down to the canteen for something.

Q. And you would spend your own money to eat at the canteen?

A. Yes. I spent my own money from the presents; I took it up there.

Q. Were the men on L-3 allowed to keep their own personal belongings, such as radios and TVs and books?

A. Well, sometimes the attendant would take it from them. As soon as you'd go down to the mess hall and come back the stuff would be gone. You see, they'd make everybody go out.

Q. Did you just tell me that sometimes the attendant would take the radios away?
A. Radios sometimes, sometimes like the clothes or something.
Q. They would take away the clothes?
A. Yes, or something the parents would give them.
Q. What would happen when they took the radios away? Did you complain?
A. Yes. I went down, I said to the girl, you can take their stuff but you don't take my stuff from me. I
[8-26] wasn't no kid you were playing with.
Q. And did sometimes the parents and the friends of the other men complain?
A. They would complain about it.
Q. And did the people get their possessions back?
A. Half we'd get them back.
Q. But they had to complain?
A. Yes. See, the parents come up there.
Q. Were the men in L building allowed to go where they wanted to and do what they wanted to do when they went walking?
A. I would take a walk down by the farm, like over in the big field, with a friend of mine.
Q. Did you have to follow the rules at Pennhurst?
A. Well, some rules, they was all right. Some rules, they would make up their own rules, you don't do this and you couldn't do that.
Q. What kind of rules?
A. Like we couldn't go down by the kitchen and wait to get in. Sometimes they will tell you you go down to the mess hall and wait until you get in, to get away from the dorm.
Q. And what would happen to the men if they did not follow the rules?
A. They'd put a conduct on them.
Q. What was that?
A. A conduct on them.

[8-27] Q. Were they sometimes punished for not following the rules?
A. Yes. They'd put them in their rooms, like that, and they would not be free to go to mess hall and they'd bring their tray over to them.
Q. How long would they have to stay in the room?
A. Oh, about two weeks. Some would stay in for five days.
Q. They stayed for five days in the same room?
A. In the room.
Q. And they weren't allowed to go out to get their own meals?
A. No.
Q. Is Pennhurst a good place to live?
A. No.
Q. That's enough about Pennhurst. Let's talk about where you live now.
A. All right.
Q. Where do you live now?
A. 336 North Street.
Q. And who do you live with?
A. Reverend Cobb.
Q. And how many people?
A. There's twelve in the house.
Q. Tell me about the house that you live in?
A. Oh, it's pretty nice. He fix up the basement for me and my brother. It's pretty nice there.
Q. Do you have your own room?
[8-28] A. There is one big room downstairs.
Q. For you and Herman?
A. Yes.
Q. Do you have your own closet and your own drawers?
A. Yes, we have our own closet.
Q. Do you have your own television?
A. Yes, I got my own TV.

Q. Do you think that's a good idea to have your own belongings and your own TV?
A. Right.
Q. Why is that?
A. If we were together there'd be a lot of fights. If you have your on TV you'd be better off.

BY THE COURT:

Q. What do you like to watch on TV?
A. I watch like Channel 29, like Clark Gable or something like that, or Power Street, something like that.

BY MR. LASKI:

Q. Does anybody tell you when you can watch it and what you have to watch?
A. No.
Q. Do you think that's good?
A. Yes, that's right.
Q. Are you working now, Mr. Hill?
A. Yep.
[8-29] Q. Where do you work?
A. Up at a deli —
Q. What is your job there?
A. I got a job going around and picking up forks, pick the pots, and taking out trash and dumping stuff on the tables for the guys that work on them.
Q. Do you work every day?
A. Five days, except holidays and Saturday and Sunday.
Q. Do you do other work for the neighbors?
A. I go around and clean up the yard for them.
Q. Do you get paid for that?
A. Yes, they pay me.
Q. What do they give you?
A. Some give me five, four, three. If it is a big yard they give me about ten dollars.
Q. So you do a lot of work around?
A. Right.

Q. What do you do when you are not working?
A. Oh, I take a walk or go fishing.
Q. Do you like to go fishing?
A. Yes, I like to go fishing.
Q. When is the last time you went fishing?
A. Last Saturday.
Q. Did you catch anything?
A. I caught one. One Saturday I caught ten.
[8-30] Q. Do you read the newspapers?
A. Yep, read them.
Q. Do you read books?
A. Books.
Q. What kind of books do you read?
A. I read like — no sex — murder stories, like that.
Q. You don't like murder stories?
A. Yes, I read them.
Q. What kind of other ones do you like?
A. Well, I look up a dictionary or something like that.
Q. Are you registered to vote?
A. Yes.
Q. When did you do that?
A. I started, I filled the papers out and I got my card. They told me I'd be ready for the next time we have an election, to vote.
Q. Do you plan to vote in the next election?
A. Right.
Q. What do you feel is better about your life now with Reverend Cobb than it was at Pennhurst?
A. I go out — you know, you can't go here, you can't go there. It's pretty nice there.
Q. And you can do what you want to do?
A. I don't stay out all night long, you know. I don't go out.
Q. Can you summarize at all why it is better to live
[8-31] in the house than it is at Pennhurst?
Q. Okay. You can't go where you want to go and you end up, they tell you what time.

Where I stay at now I can pick what time to go to bed and what time to get up. I can just do what I want; that's all.

* * *

[8-33] **Testimony of Herman Vaughn**

BY MR. LASKI:

Q. Mr. Vaughn, where do you live?

A. 336 North Street.

[8-34] Q. How old are you?

A. Thirty-six.

Q. Did you live at Pennhurst?

A. Yes, I do.

Q. How many years did you live at Pennhurst?

A. Thirteen years.

Q. In what building did you live?

A. Penn Hall 2.

Q. Tell me, what was it like at Pennhurst in Penn Hall 2? Is it a good place for people to live?

A. No, sir.

Q. Why do you think it is not a good place for people to live?

(Reporter's note: From this point on the testimony of Mr. Vaughn as follows was constructed using stenotype notes and a tape recording.)

THE WITNESS: Because they treat you mean and all that.

BY MR. LASKI:

Q. How do they treat you mean?

A. They want to slap you, slap you around.

Q. Who slaps you around?

A. The attendants.

[8-35] Q. Could you come and go as you wanted to from Penn Hall?

A. No.

Q. Could you watch TV and listen to the radio or play the stereo by yourself?

A. No, I couldn't.

Q. Were people sometimes hurt at Pennhurst?

A. No.

Q. Were they sometimes slapped around by the attendants at Pennhurst?

A. (Unintelligible.)
Q. Were people sometimes punished at Pennhurst for not following the rules?
A. Yes, sir.
Q. In what ways were they punished?
A. Like you, when you want to run away to (unintelligible).

Then you were going to places that you would go out, and at the desk, you can't — (unintelligible) —

Q. And what did you say?
A. And I said why I can't go.
Q. And do they give you a reason why you couldn't go.?
A. No.
Q. Were there times when you had to stay inside Penn Hall?
A. Yes.
Q. Could you go outside after six o'clock?
A. No, no.
[8-36] Q. Were there some times the men were punished by staying in Penn Hall for a long period of time?
A. Yes, you do.
Q. How long?
A. (Unintelligible.)
Q. Were they allowed to leave the building?
A. No.
Q. Did you work at Pennhurst, Mr. Vaughn?
A. Yes, I did.
Q. What kind of work did you do?
A. I used to take the trays to the kids in the ward, dress them and bathe them and soaping them.
Q. And did you work every day taking care of the patients?
A. Yes, come in at seven o'clock in the morning.
Q. And in what wards did you take care of the patients?
A. U-2.

Q. What were the clothes like at Pennhurst?
A. It's a green — green pair of pants and a brown shirt.
Q. Did everybody wear the same kind of clothes?
A. They do, yes.
Q. Did you get paid for your work?
A. No, I didn't.
Q. Did you sometimes take care of the patients on Saturdays and Sundays?
A. Yes, I did.
[8-37] Q. Did sometimes the patients have visitors on Sunday?
A. Yes.
Q. And did you have any jobs on Sundays?
A. No, sir, the only time is when (unintelligible) — you had a piece of paper, a slip, and take them to the ward, to the attendants, and then you dress them, and take them, down to the office.
Q. Did you ever get any money for doing that work?
A. No.
Q. Tell me what a day was like living at Pennhurst. What time did you get up?
A. I got up at around between seven o'clock in the morning and going to work at seven and I worked until one.
Q. What happened at one?
A. Then I'd go back to Penn Hall and then go down to get something down — I went down to Penn Hall, I found my clothes on the floor, my bed messed up (unintelligible) — they took all my clothes out of my closet and throw them on the floor.
Q. Had you cleaned your room in the morning?
A. Yes, I cleaned my room in the morning.
Q. In the evenings — what did you do in the evenings after work?
A. I believe all I could go up the hill to talk to my girl, and it was a cop there named Ames. I asked the

cop — (unintelligible) — and they wouldn't let me
|8-38| and I — down to him to the canteen.
Q. Are you telling me you weren't allowed to go up the hill to talk to your girl?
A. No.
Q. You didn't have permission to do that?
A. No.
Q. Did you ask for permission?
A. Yes, I asked and he told me no.
Q. Did you ever have any money at all at Pennhurst?
A. I had my aunt gave me money.
Q. And were you allowed to keep that money?
A. No, I didn't — couldn't have it.
Q. What happened to that money?
A. The 'tendant take — the superintendent, the superintendent take it off of you, but one time when I go back to ask the superintendent could I have the money, the superintendent gave the money (unintelligible) somebody else (unintelligible).
Q. You asked the superintendent whether you were allowed to have the money?
A. The money.
Q. And what happened then?
A. He gave it — (unintelligible) — to a nurse — (unintelligible).
Q. Your money was given to somebody else?
A. Yes.
|8-39| Q. And you did not get it?
A. No, I didn't get it.
Q. That's enough about Pennhurst, Mr. Vaughn.
Tell me about where you live now. What is your home like?
A. Fine.
Q. Who do you live with?
A. Reverend Cobb.
Q. Could you describe the rooms where you live?
A. It's fine. It's pretty good, yes.

Q. And do you prepare your own meals at that home?
A. (There was no response.)
Q. Do you help prepare the meals at home?
A. No, I don't.
Q. Do you help to wash the dishes at home?
A. Yes, I do.
Q. Do you help to clean up?
A. Yes.
Q. Do you have a job?
A. Yes, I do.
Q. And what is your job?
A. I wash dishes at Strawbridge & Clothier. I wash dishes.
Q. Do you have to go to work today?
A. Yes, sir.
Q. How many days a week do you work?
[8-40] A. Five day a week.
Q. And how do you get to work? How do you travel to work?
A. My dad take me in the morning, between eleven-thirty, and I take the bus to come home at nighttime.
Q. And how do you get back from work at night?
A. By the bus.
Q. Is that a long bus ride?
A. Yes, it is a long ride from Springfield to Chester, yes.
Q. How many buses do you have to take?
A. I take the 69th Street bus that goes to Chester, and I take the 76 that comes to Chester, and then that bus 76 don't come until quarter of ten.
Q. Do you get paid for the work at Strawbridge & Clothier?
A. Yes.
Q. Do you get a check every week?
A. Every Thursday.

Q. Are there any other benefits that you get from working at Strawbridge & Clothier?
A. Yes, I do.
Q. What are those?
A. Like they have parties, go to a benefit.
Q. Do you get any benefit on making purchases and buying things at Strawbridge's?
A. Yes, twenty off.
Q. And do you go shopping and what do you buy?
A. I buy records, tapes —
[8-41] Q. Do you have your own stereo?
A. Yes.
Q. Does anybody tell you when you can play your stereo?
A. No.
Q. Do you play it when you want to?
A. Yes.
Q. What do you do when you are not working on Saturdays and Sundays?
A. I go in the back yard and play my stereo.
Q. What else do you do?
A. Sometimes I go to town shopping, out to Springfield, do my shopping.
Q. Do you have to ask permission when you want to go shopping?
A. No.
Q. Do you go to church on Sunday?
A. Yes.
Q. Do you help out sometimes at church on Sunday?
A. Yes.
Q. And what do you do at church?
A. I sing, like sing, put the people down, sitting down in church.
Q. Do you work at the church?
A. Yes.
Q. Do you mean in the choir.

[8-42] A. No, not the choir; just an usher.
Q. You are an usher?
A. Yes.
Q. Is life better living in Chester than it is at Pennhurst?
A. Yes, you do.
Q. And what makes you think that it is better at Chester than it was at Pennhurst?
A. Chester is better. You have more freedom in Chester than you have in Pennhurst.
Q. You have more freedom at Chester than you had at Pennhurst?
A. Yes.
Q. Now explain to us what you mean by having more freedom.
A. In Pennhurst you cannot have no downtown at all. In Pennhurst you cannot do anything you want to do; and another thing, in Pennhurst, they ask you if you want to go to work, you can have to stay in your room at all.
Q. And you can do what you want to do in Chester?
A. You can do whatever you want to do in Chester.
Q. Do you think Pennhurst is a good place to live?
A. No.

* * *

BY MR. FERLEGER:

[8-43] Q. Do you still think about Pennhurst sometimes?

A. Yes, I do.

Q. When you think about Pennhurst sometimes what do you think about?

A. I think at Pennhurst they treat you mean.

Q. Are you ever afraid of going back to Pennhurst?

A. No, I don't want to go back there.

Q. Do you ever worry that you might have to go back?

A. No.

* * *

[8-45] **Testimony of Mrs. G. Auerbach**

DIRECT EXAMINATION

BY MR. GILHOOL:

Q. Where do you live, Mrs. Auerbach?

A. I live at Philip Murray Senior Citizens Apartments, Stenton Avenue and York Road.

Q. Please sit down.

A. Okay. Thank you.

Q. Will you tell the Court of the milestone dates in your life?

A. Do you mean when I was born?

Q. That sort of thing.

A. I was born in March 1900. I am seventy-seven years old and I was born in Russia, came to this country in October 1909, so I wasn't quite ten years old when we came to this country.

Q. And thereafter?

A. Thereafter I went to school and in 1919 I was lucky enough to get married. Then I had two boys, one in 1921 and another one in 1925.

Q. Is one of your sons retarded?

A. One of my sons is retarded, the younger one, Sidney.

Q. And how old is Sidney now?

A. Sidney is past fifty-one.

[8-46] Q. Where does Sidney live?

A. Sidney lives now in the Ashbourne Terrace Apartments, at 6060 Crescentville Road.

Q. And that's in the Lower Northeast?

A. The Lower Northeast Philadelphia.

Q. With whom does he live there?

A. He lives with two other boys in a two-bedroom apartment, completely furnished for housekeeping.

They have one bathroom for the three boys and two bedrooms — one large bedroom Sidney shares

with another boy, and the other bedroom is a smaller one and one boy lives there.

Q. And who operates that apartment at that address?

A. The Ralph Bruce Nippon Association. The Ralph Bruce Nippon Association are responsible for Sidney being taken out of Pennhurst.

Q. And how long has Sidney lived at that apartment at Ashbourne Terrace?

A. Well, when he first came out of Pennhurst they had a house at — I think it was 1410 Chelten Avenue. He lived there — he came out of Pennhurst October 1973 and they lived there, I would say, about two years, because it's three and a half years since Sidney is out and they are in Ashbourne Terrace about a year or past a year, three boys to one apartment.

Q. Does Sidney work?

[8-47] A. Sidney works at the PARC Workshop, 24th and Westmoreland.

Q. And how does he get there?

A. He gets there by taking two buses to go to work and two buses to come home.

Right now the buses are not working; they have a minibus that takes them to work.

Q. You said that Sidney left Pennhurst in October of 1973.

When did he go to Pennhurst?

A. We took Sidney to Pennhurst in March of 1935.

Q. Do you have greater peace of mind now that Sidney is living in the community than you had when he was living at Pennhurst?

A. There is no comparison, because Sidney now is living a good life. He is living a normal life and when he was at Pennhurst there was nothing to look forward to. It was hopeless. It was just — he was just a number.

Q. Do you feel more secure about Sidney's welfare now than you did when he was living at Pennhurst?
A. I most certainly do; I most certainly do.

I am getting on and I feel that when my time comes Sidney is in the right hands and will be able to take care of himself, which he is doing now.
Q. What differences do you see in Sidney now that he has left Pennhurst and is living in the community?
A. Well, as I said a moment ago, sir, the life now is a normal life. Sidney goes to work, he has a bank account, he keeps house.

[8-48] He called me last night and told me he was made in charge of the kitchen, and I want to tell you that kitchen is going to be well taken care of because one of the things that Sidney has developed is being a boss, very bossy, and he will see to it that the kitchen is going to be kept clean, immaculate.
Q. This is the apartment kitchen?
A. It is the apartment kitchen.

They have a beautiful living room with dining area. They have entertained me. Sidney has made dinner for me, for my birthday, for Easter, for his birthday, and he entertains me, as I entertain him and his friends. When I have time they come up on Sunday for brunch and now they are looking forward to resuming it as soon as the strike is over.
Q. What are some of the things that Sidney does now that he didn't do at Pennhurst in addition to the shopping and the cooking that you mentioned?
A. Well, he is leading a normal life. He gets up in the morning. He has a job. The Nippon Association provides wonderful programs for them for the weekend.

He has taken trips. Two years ago he went to Mexico. One year they went to Canada; going to Atlantic City is an everyday thing now. It is not such a big deal any more.

They have been to the United Nations, they
[8-49] went to Disneyland one summer.

And he buys his own clothes. They had a dinner at Palumbo's in December and Sidney was all dressed in a brand-new outfit and he said, "Don't you think I look like a thousand dollars?"

I said, "No, I think you look like a million dollars."

And for that he wanted to go buy me a drink.

Well, the fact that he asked me to buy him a drink, that was a big moment in my life because Sidney has — I mean there is no comparison to the way Sidney was when he was at Pennhurst.

There he was a number. He was subdued. He never talked and now you can't stop him and everything he says makes very, very good sense, very good sense, as my friends in the building have noticed.

I have lived in this building for ten years and they saw Sidney before he came out of Pennhurst when I used to bring him home for weekends and they see him now and there's just no comparison, everybody notices it. He is well-known in the building. He is the belle of the ball.

Q. Mrs. Auerbach, you said that when there isn't a strike on at least Sidney Auerbach travels to work by taking two buses and a change.

Will you explain to the Court how he learned to
[8-50] travel those buses?

A. Well, I don't need to say how scared I was when they first said that Sidney is going to have to take two buses to go to work — how is he going to cross Broad Street or York Road?

And they have trained staff that help these boys out and they explained to me what they do. When they moved from Chelten Avenue to Crescentville Road they had an entirely different route to go to work.

One of the staff gets on the bus with them and shows them certain spots that they pass as landmarks, and I suppose they continue that for about a week until they are sure that the boys feel certain that they will know how to get there.

After that, she follows them. They get on the bus themselves, but she follows them in her automobile just to see that they get off at the right place; and that goes on for a week or more until she is certain that they are sure of knowing how to get there. After that they are on their own.

Of course, they have identification cards and they take two buses and when they get off, I think it is 23rd and Hunting Park, they have one block to walk, to 24th and Westmoreland; and they work in the workshop.

They are through there around four-thirty. I think it is from eight o'clock to four-thirty.

Q. Is Sidney going out to adult class at Girls High to learn other things?

[8-51] A. Yes, Wednesday night. Last night was Wednesday. They were there; the minibus took them and the complaint was that they got out a little too early, so the minibus wasn't there for them when they were ready to go home, so they were probably in some drug store having sodas.

Q. What is your son learning at the class at Girls High?

A. At the PARC workshop he packs things. This is a —

Q. I am sorry.

A. What he is learning in Olney High School. It's the Girls High School. It is Broad and Olney, the Girls High School, and he was taught how to cook.

As a matter of fact, last summer, at the closing session, I was invited to see what they had done and I went there. They had all kinds of cakes and salads on display that the boys had made.

Q. And what are they teaching him now?
A. They teach him — they try to teach him how to read and how to tell time and he does take to learning. They can teach him things because the things he is doing now I would have never believed that my second son would have been capable of doing these things.

He's learned more in the three and a half years than he did in the thirty-eight and a half years he was in Pennhurst.

[8-52] Q. Tell me, what differences have Sidney's new life made to you?
A. I don't know where to start, but I can tell you that I have peace of mind. I know that my Sidney is on the right track, that I don't have to worry about what's going on because listening to some of the things this morning brought back to mind bad memories that I don't wish to recall and there is no comparison to how I feel about Sidney's life now in comparison to what it was when he was in Pennhurst.
Q. How —
A. It's all to the good. I mean he is leading a normal life. He gets on the bus to go to the barber shop himself and he knows when he has to go to the barber shop.

He buys his clothes and they make up their own shopping list and they shop and he is doing the cooking.

The three boys — each one takes a turn doing the cooking, but he sees to it that the kitchen is cleaned up after all the cooking is done.
Q. Mrs. Auerbach, will you tell the Court how Sidney came to be at Pennhurst way back in 1937?
A. Well, Sidney was born in December of 1925 and in August of 1926 I was told by my doctor, a pediatrician, that Sidney was mentally retarded and that he would never develop. As a matter of fact, the doc-

tor decided that he would never see and he would never have teeth.

[8-53] Now the boy was only eight months old. My other boy was four years and nine months old at that time, healthy, a healthy specimen, thank God.

So he said I know you are not going to listen to me, you are going to start spending your money. Don't do it. Save it and send this boy to college.

Well, of course, the very next thing I did was go to another doctor and I went to many, many doctors and the answer always came out the same; but who can put away to Pennhurst or any institution a child that's eight months old, so we kept him home.

Q. What was the answer that came out the same? What did each of the doctors say?

A. Each of the doctors said the answer was the same — the boy has to be put in an institution — and we weren't going to put our boy in an institution when he was eight months or a year or two years.

And then he was six years old and I wanted to put him in the public schools and there was absolutely no place in the City of Philadelphia for my Sidney.

We finally found some kind of a special class in a school, the Elverson School, that's what it was called, at 13th and Susquehanna, and we lived at 17th and Susquehanna at that time.

So he attended that class for two — so for two
[8-54] years I walked four times a day those four blocks to take Sidney to school and bring him home.

And the only reason she kept him the extra year is because he was well-behaved, but he made no progress whatsoever.

Well, after that, we started thinking about putting him away and that was a terrible decision to make, so it took almost two years for us to make up our minds to put Sidney away because then it was impossible to keep him home.

Our other boy was getting isolated. He wasn't bringing any friends in the house. It was not good, so we decided to put him in Pennhurst, hoping against hope that someday something good will happen and that he can come out and lead the good life, lead a normal life.

And that was it, but there never was any kind of a program until the Nippon Association came into being in, I would say 1967, when they started to talk to me at Pennhurst about taking Sidney out and putting him in a group home. This was a shock to me.

Q. It was shock?

A. Yes.

Q. What did you think when it was first proposed?

A. How is Sidney going to live, integrating into the community, after being in an institution for thirty years? He was out thirty-eight years.

[8-55] When he came, he was there thirty-eight years when he came out, so this had to be like thirty-five or thirty-four years, for most of his life in an institution and then to put him in a place where he is going to be an individual and take care of his own needs? I can't — I couldn't figure that out, but they had to talk to me too.

They did and I am glad I listened to them.

Q. At first you resisted the idea?

A. I certainly — I didn't resist it but I kept saying how is it going to be, how is he ever going to be able to lead a normal life when he has been leading a sheltered life.

Q. Were you worried?

A. I was terribly worried. I was terribly worried.

This young man who was his counselor at that time — when I heard the names of the buildings that the young men just mentioned my Sidney was in all of them. He was in L-3, L-2, and then he ended up in — at that one up the hill, Penn Hall.

Penn Hall 2, that was supposed to be good already because I think they had like twenty-five boys on a floor.

Q. Instead of —

A. Instead of 150 or 160.

Q. You said you were worried when it was proposed.

Would you say you were scared when it was proposed that Sidney come out?

A. Yes, because I am a widow. My husband died in
[8-56] 1966 and I was left, and my oldest son moved to Atlanta, Georgia.

I really had nobody here to talk to. Well, I have two sisters and they are both widows and they have got their own troubles.

I didn't know what to do. I didn't know what to do and I was scared that the change would be for the worse, but I was told that Sidney has the potential and that he is entitled to have that opportunity to live the normal life, even if we think right now that he can't, he is entitled to that opportunity.

Q. And so you said yes?

A. So I said yes; that's right.

Q. When did you stop worrying?

A. Well, when they really got the wheels rolling about taking him out. I would say he came out in October of '73, I would say offhand, like you say, April of '73, this young man who was his counselor, his first name was Tom and I can't remember his last name — he became like one of my family. I had him down for lunch and for dinner, I don't know how many times, because he wanted to talk to me to make sure that I feel right about it.

And I finally said okay, Tom, let's go, go ahead; and he did and Sidney came out on October 31, 1973.

That house on Chelten Avenue is around the corner from where I live, and the Nippon Associ-

ation were responsible for this change and the executive director of that organization called me and
[8-57] said, "Now, look, Grace. You stay away from Sidney for two weeks. Stay away until we tell you it is all right to come and visit him."

I could see the bedroom from my apartment, so it was pretty hard for me to stay away, but I did, and I didn't have to wait two weeks.

They called me up about a week afterwards and they said it was all right, would I like to come and have dinner; and this was a home. They had a wonderful woman in charge and she called me up and asked me what Sidney likes best to eat, and I told her and she made sure that she had that, because I didn't dare to call up that night when he came, but I had a friend of mine call up to see how is Sidney reacting. He ate and he was happy, so, of course, I was happy.

Q. When did you become very confident that Sideny was going to make it in the community?

A. Well, Sidney had to cross York Road, and I couldn't see that with the two-way traffic, so they'd call up he was coming over and I'd be downstairs waiting for him, and I was a little bit late getting downstairs to meet him.

And when my door bell rang there was Sidney. He walked into the lobby, he pushed the button for the elevator, and he found my apartment by himself; so after that I didn't have to worry.

Whenever Sidney wanted to come over he
[8-58] came over and that was it and that's how it is, your Honor.

Where he is living now he takes one bus, the K bus; he knows where to get off and there he is.

Coming back he has to walk three blocks to take the K bus and he does that.

But most of the time he comes over with his friends. I have them over for brunch on Sundays and I will when the buses will start running again.

[8-159] **Testimony of B. Hare**

* * *

BETTY HARE, having been duly sworn, was examined and testified as follows:

MR. LASKI: Dr. Hare has been qualified as an expert in mental retardation, in the education and training and other habilitation of other mentally-retarded people, and evaluation of programs for the mentally-retarded and the design and conduct of research in habilitation programs for the mentally-retarded.

Just as previously with the testimony of Dr. Flueck, the records shown for the sample study survey that Dr. Hare will be testifying about are in the courtroom for the examination of the defendants, if they choose.

DIRECT EXAMINATION

BY MR. LASKI:

Q. Dr. Hare, did you participate in designing the conduct of a sample study of Pennhurst records?

A. Yes, I did.

Q. And what was your role in that study?

A. John Flueck supervised the quantitive analysis and I designed and supervised the qualitative analysis of the records.

[8-160] BY MR. LASKI:

Q. I show you a document marked PARC Exhibit 52. Do you recognize that document?

A. Yes, I do. They are the forms that we used to record our analysis of these records.

Q. And how did you proceed in this analysis?
A. An experience schedule in program design and delivery was assembled. The members included Eleanor Elkin, past president of the National Association for Retarded Citizens and the current chairperson of the National Association's Residential Services Committee, a consultant to the Joint Commission for Accreditation of Hospitals for Community Services and a qualified and experienced evaluator of programs for mentally-retarded people, under several evaluation teams, including the Program Analysis of Service Systems.

Carla Morgan, who for several years was Director of Community Programs in Bucks County, a member of the Bucks County MH-MR; for several years director of the Westmoreland County Association for Retarded Citizens and director of its programs, and again a qualified evaluator.

And Deborah Spitalnick a doctoral candidate in clinical psychology with extensive field experience in programming for retarded people at St. Christopher's Hospital for Children, Woodhaven Center, and the Fernald State School and Hospital in Massachusetts.

[8-161] Miss Elkin is a consultant to the Public Interest Law Center. Miss Morgan is an employee of the Public Interest Law Center.

Among us we spent 230 hours rating and analyzing these records an average of nearly two hours per record; and another forty hours planning and summarizing our findings.
Q. And what were the focal questions of your study, Dr. Hare?
A. There were four focal questions.

First, we looked to see whether there was current multidisciplinary assessment; second, whether there was a program plan; third, whether there was

an individual plan; fourth, whether there was evidence in the record of regression.

For the current multidisciplinary assessments we asked whether there was full, partial, or no assessment at all, That's Question Number 1 on this form.

Our criteria for decision were whether there showed on the record a determination of the client's strengths and weaknesses, skills and definits, learning styles or present learning functioning at a given time by all the disciplines relevant to such a determination for that person.

Our criterion for current was a two-year period or January of 1975. This is, indeed, a minimum standard. A long-standing professional standard would require annual assessments.

Title 19 of the Social Security Act requires an-
[8-162] nual assessments, as does JCAH and an array of court decisions based on those standards, both in treatment and in education.

In applying these criteria we sought at each point of judgment to resolve in favor of the presence of the item. For the current program plan we asked whether there was a full, partial, or no program plan at all. That's Question Number 2 on the form.

[8-163] THE WITNESS: The criteria for decision were, considering the assessments, whether there was present (1) the identification of long and short-term goals, including priority goals, and the specification of objectives necessary to achieve them, all expressed in behavioral terms;

(2) The specification of the conditions under which the client will achieve the objectives, including the site, the person responsible, the materials to be used, and the teaching methods employed;

(3) The specification of the criteria for evaluating mastery of this objective; and

(4) Specification of the method for recording progress toward mastery.

These criteria again are commonly-accepted professional standards. Many of the witnesses who preceded me spoke about them and their justification.

We have learned, in fact, that in order for systems to be attractive these components must be there. These are the kinds of things I require of my students in teaching.

Again, applying these criteria, every benefit of the doubt was made in favor of its existence and any
[8-164] indication we recorded as partial. In order for a full program plan to be accredited all elements had to be evident.

For the exit plan, which is Question 3 on the form, we asked whether there was a full, partial, or no exit plan at all. The criterion for decision was the presence of specifications of the program necessary for the person to live in the community, including a place to live, activity during the day, and health and other supportive services.

Further, we looked for specification of the person responsible for the coordination and implementation of the plan; and again we were very generous in scoring.

For evidence of regression we asked whether there was in the record explicit evidence of regression, that is, statements by Pennhurst staff that, for example, a client had lost skills once possessed or that maladaptative behavior or symptom was worse or more frequent than it had been; or, for example, the juxtaposition of two statements — first, a statement that a particular behavior exists, such as John

speaks in sentences, and then a later statement that might have referred to this non-verbal boy.

Page 3 of the form shows that we required such evidence in respect to eight areas of behavior — speech, social interaction, toileting, washing, showering, dressing, eating and mobility.

We scored the presence of regression as no in-
[8-165] dication or yes.

Then this measure itself is conservative. No indication is really not to say that no regression occurred, but merely that it was not found.

BY MR. LASKI:

Q. Dr. Hare, I show you document marked PARC Exhibit 53. Do you recognize this document?

A. Yes.

Q. What is that document?

A. This is the results of our study.

Q. Will you briefly read what the tables show?

A. Yes.

Table 1 denotes the findings related to multidisciplinary assessments.

We find that no clients had a full multidisciplinary assessment. 79.4 percent had partial assessments and 20.6 percent had no assessment since January of 1975 at all.

We were surprised that there were no multidisciplinary assessments and so many with nothing at all. The partial group is a large figure. If we had been able to predict this in the beginning we would have coded much more specifically.

I think it is important for you to know what the bulk of partials look like. The evaluations were
[8-166] mostly from Psychology, from Occupational Therapy, and Speech and Hearing. Only rarely was there a section by the vocational adjustment service, special education, or self-care.

Table 2 on this form sets up the results of the program plans. Again, we found that no client had a full program plan; 71.1 percent had partials; and 28.9 percent had no program at all.

Where some elements of the program plan occurred they tended to be the annual program review form, the annual commitment review form, and reports of team meetings.

In most cases the people who did the assessments were not present. The psychologist was there but the occupational therapist and speech and hearing therapists were not. Thus, even the partial program plans were not, as should be necessary, based on the partial assessment.

The partial program plans most frequently included a statement of goals or objectives. The statements were seldom precise and seldom in measurable or behavioral terms.

For example, one that we encountered quite frequently was, "To increase environmental stimulation", or "To encourage family involvement." They do not state what the client should do, where he would do it, or how he would do it or how we would know if and when he had done it.

The other element-specification of conditions,
[8-167] criteria for mastery and documentation of implementation, was virtually non-existent.

In only one case was the client present at his program plan. In no cases were parents there. There was no indication of the presence of a Base Service Unit representative.

Table 3 reflects our findings on the exit plans. Again there was no full exit plan for any — zero percent. There were partial exit plans for 39.2 percent and there were no exit plans for 60.8 percent.

Whenever there was recorded evidence that a group home or foster home ought to be actively pursued this was credited as a partial plan. For example, if they said movement to Woodhaven, so he could have one-to-one involvement, we gave that partial credit.

In virtually no cases was there specificity of the sort of placement or the sort of programs that ought to be provided by the community and no specifications of who should be responsible for the placement.

Table 4 on this form reports the documentation of evidence of regression in the records of 34 percent of the Pennhurst clients. There was no documentation in the rest. However, it does not necessarily follow that no regression occurred in the other 66 percent. It was only not explicitly noted in the record.

[8-168] Q. Dr. Hare, have you had the opportunity to read the records of Charles DiNolfi, David Preusch, Jo Suzanne Moskowitz, and Robert Hight, individual plaintiffs in this case?
A. Yes, I have.

Q. And are these training and evaluation records characteristic of the 124 records that you studied?
A. Yes, they are.

Q. Will you please tell us of the characteristics which those records share with the 124 records studied?
A. They are typical of the entire group in many ways. There is a general lack of multidisciplinary assessment, at best partial program planning and exit plans and notations of regression.
Q. Is the Charles DiNolfi record typical of the 124 you have studied?

A. Disciplinary assessments include psychological and speech and hearing evaluations. In Mr. DiNolfi's case there were also recently-completed forms for an annual program review and an annual commitment review. Neither of these noted the exit plan, except both, to remain as committed until he is able to move into a group home in the community.

I found ample evidence of Mr. DiNolfi's ability to move into the community.

I would like to leave my notes for a moment and state that I feel as if I know these individuals very
[8-169] well, though I have never met them.

Mr. DiNolfi is the kind of man that I really admire. There is ample evidence in that record that this is a man who, despite many handicapping conditions within himself and outside of himself managed to beat the system. Example:

His program is essentially free time, which has allowed him to learn to go about the entire Pennhurst campus unescorted. He knows which buildings he can enter and which he is not allowed to enter. He knows when to go back to his unit — mealtime. He has learned that whole Pennhurst community and managed it on his own.

The record states that he enjoys going to the canteen. He uses money in that canteen to buy food, to buy soft drinks.

There is also evidence that he has learned how to manipulate people. He knows how to get money by approaching; he knows the right people to approach, all of this despite the fact that he has very minimal expressive speech.

Back to my notes.

Mr. DiNolfi has developed discrimination and problem-solving ability. One the psychology report

dated September 19, 1975, I quote, he will remove another resident's article of clothing if it is inside-out, but replaces it correctly.

[8-170] I found this particularly interesting because scattered throughout the ward notes there are frequent notations as to Mr. DiNolfi removing clothing from other people. There were also notes that Mr. DiNolfi "steals" clothing and hoards it.

Further reading provided some evidence that this man is very particular about his appearance. There are frequent mentions that his clothing fits, that he insists on being neat, and he continuously searches until he can find the kind of State clothing in which he is comfortable. Again, this is evidence that this man could be quite self-sufficient.

Back to my notes.

Although the speech evaluation refers to his using speech in both single words and phrases throughout the evaluation, the recommendation was to teach him manual language. This attempt was terminated after six months because Mr. DiNolfi "lacked interest".

I could react to that.

Q. Would you please react to that, Doctor?

A. As a schoolteacher, once she has evidence of a skill that automatically provides a basis for intervention and training, if a person demonstrates something you know he can do it. It is true with certain handicapped individuals who may have hearing we have been attempting some manual language and signs. This is, however, primarily for those persons

[8-171] whose expressive language is almost completely non-existent, usually because of some emotional factor such as an aphasia or an autistic-like condition.

The fact that for some — more than thirty-five years — Mr. DiNolfi had, although very limited, some verbal speech, I would question whether or not to introduce a whole new system would have been the appropriate intervention, but I would have suggested that continuing work with the basic speech that he already had should have been the basis for further extensions of that.

Now I may be responding inappropriately to this because all I have, as I say, is the record; but again from my professional viewpoint, I would have questioned that and I would have certainly been concerned if that was a unilateral decision and not a team decision that signings should have been the appropriate speech development for him.

Q. Dr. Hare, how is David Preusch's record typical of the 124 records you went through?

A. David's record recorded quite direct current assessment shows quite minimal as only audiological and speech evaluations were found. His program plan is only partial also. The goals identified on July 10, 1975 included independent toilet training, dressing, self-help skills, and to correct David's walking with physical therapy and the aid of a brace on the right leg.

It does not specify, except under the umbrella [8-172] term "self-help", but there was an earlier plan for tooth-brushing, which was terminated on January 28, 1975 because he made "minimum progress".

There was no exit plan.

Regression was noted in his feeding skills, a ward note dated 1974 stated he can feed himself while in February 1975 there is a statement, "At one time he would feed himself fairly good. Now he won't even feed himself."

There were also conflicts between gains made and recorded on the school record which were not transferred to his ward behavior.

Q. Dr. Hare, would you please tell the Judge how Jo Suzanne Moskowitz's record is typical of the 124 records you ran your study on?
A. Jo Suzanne's records record only audiological and social service evaluations during this current period, so her record was scored a partial for multidisciplinary assessments.

Again, I think I know this little girl. At a team meeting on March 9, 1977 attended by a psychologist, speech therapist, occupational therapist, social worker, resident life aide, nursing staff member, and someone referred to act as IS representative, it could have been any number of persons.

The goals stated were self-help skills and to decrease soil-smearing and clothes ripping.

[8-173] These were the same goals that appeared on her first program planning six years prior to that date. The DU plan was scored as partial. This was one of the bases of the following statement:

Placement at Pennhurst to continue until an alternative, such as Woodhaven, could be accomplished.

I must comment I was even hesitant to give that partial credit because that is not really an exit plan; it does not meet the criteria.

Again and again throughout the records that I saw evaluated I noticed a paucity of communication among the personnel of the various disciplines and a lack of program implementation when it is obviously warranted.

I mentioned that I felt that I almost knew Jo Suzanne. There are some very interesting comments made by ward workers and teachers, a very heartening one appeared. This was Jo Suzanne's day. The teacher assistent had put her on the toilet. Jo Suzanne reached for something, the teacher stopped her, and said don't, you might break it; and Jo Suzanne said, "break it" and the aide had to re-

peat it again and again, three times in succession. Jo Suzanne, a child who was considered to be non-verbal, said "break it" clearly; and the way the teacher statement wrote and documented this was really very heart-warming.

There were also references in the record as to
[8-174] her saying "okay" and hummed Christmas carols and happy birthday, yet there is no indication of a program to enhance expressive language, only the fact she doesn't have it.

Q. In your view of [Moskowitz] record was there any notation of any follow-up on the aide's indication of speech?

A. No reference, no.

There are reports that in school she has few toileting accidents, no ripping; she is learning there to dress herself and to use a spoon. In school she can identify colors, do puzzles and other fine motor activities. She identifies objects when they are named and she follows verbal directions.

I found no evidence of follow-ups on these skills on the ward.

If I am interpreting this correctly it says to me that when [Moskowitz] is off the Pennhurst grounds in a classroom she is functioning, she has skills. I found nothing in the records to demonstrate evidence of these skills in Pennhurst.

Q. Dr. Hare, was the evidence of speech detected in the schoolroom, away from Pennhurst?

A. There was a notation in the school record and there are specific sheets that are school records themselves that denote this, yes.

Q. What did you find in Robert Hight's record that was typical of the records that you analyzed?

[8-175] A. Robert Hight, of course, lived at Pennhurst for two and a half weeks. The only assessment was a psychological evaluation done on September 24,

1974. There was no program plan nor commitment plan. There was apparently, from the ward notes, some physical deterioration.

There was also a very interesting occurrence that I noted on Robert's record. There are two psych reports. The second is completely identical to the first with one difference. There is a statement about the attitude of the parents. A memorandum ordering the deletion of this sentence, although it was not removed but noted merely as erroneous is dated January 16, 1976, over a year after Robert was removed from Pennhurst.

I found a notation of September 30, 1974 also very interesting. Now this is four days after Robert left. "The Hights were overreacting to a normal adjustment period that Robert has to go through."

The ward notes for that period included the following, September 22, 1974, "He fell, sustaining minor lacerations, lower lip."

For September 26, 1974, "Slid out of wheelchair, sustaining an abrased upper right arm."

Q. Dr. Hare, in your review of the records did you note the extent and nature of the involvement of the county Base Service Units and program planning and an exit planning for a Pennhurst resident?

[8-176] A. Yes. In no cases was there recorded evidence of BSU participation in program planning. The representatives of the Base Service Units were not there.

In approximately twenty percent of the cases there was recorded some contacts with the BSU and such entries were reported on the annual commitment forms, which asked what BSU participation there had been.

I have read in the deposition of Catherine Clark, the Chief of Social Services at Pennhurst, that all Pennhurst residents have been assigned through BSU. Letters have been sent from

Pennhurst to BSU inviting their participation and giving us a copy of the annual program reviews and annual commitment reviews.

The retardation center received unique replies among the BSUs, which turn up on the records. Approximately a dozen times these were cited as having visited their clients at Pennhurst for purposes of formulating a life-management plan for the person. Sometimes there appears on the record a copy of the Montgomery County on-site evaluation.

Q. Dr. Hare, what is a life-management plan?

A. The BSUs are supposed to prepare for each of the clients a life-management plan, including those in institutions. This is a long-term habilitation plan specifying services for that person from birth to
[8-177] death, including those necessary for that person to live in the community.

Q. Apart from the Montgomery County Mental Retardation Center, what do the records reflect which are in the Base Service Unit contact and involvement?

A. Over and over again the records note contact from Pennhurst to the BSUs and no response from the BSUs. This is in approximately eighty percent of the cases.

The remaining twenty percent include the Montgomery County visits that I mentioned. The rest are simply comments about the unavailability of community services. For example, I'd like to read some of these.

In Case Number 7041 the following comments appeared on the record dated 1976 — since there are presently no appropriate alternative living arrangements, he will continue to remain at Pennhurst for further care and training. No life-management plan from the BSU has been received as of this date. For Case 9704 in 1976 — Father is interested in John's welfare and takes him home

frequently for vacations. At the present time there are no plans for community placement from the BSU.

For Case Number 9862, this is a report dated 1972 — Betty would function in a group home setting if appropriate schooling, clothes, workshops, and transportation were available.

Four years later in the annual commitment report of 1976, which was sent to the BSU, the
[8-178] Pennhurst staff noted lack of alternative; commitment continued.

For Case Number 5189, from the 1976 annual commitment review — BSU letter says appropriate community living arrangements not presently available. Recommend he continue at Pennhurst.

* * *

[8-184] Q. Dr. Hare, did you have the occasion in the course of your work to commission and/or see a tabulation of program hours delivered for sixty-eight Pennhurst residents who at one time in the past were considered for transfer to Embreeville?

A. Yes.

Q. And from what work record was that tabulation made?

A. From the answers to interrogatories by the Superintendent of Pennhurst, Duane Youngberg, setting forth the programs delivered to the sixty-eight persons during their years at Pennhurst and the hours that were spent in those programs.

Q. Dr. Hare, I show you a document marked PARC Exhibit Number 54.

[8-185] Do you recognize this document?

A. Yes, I do. It is the analysis.
Q. Have you summarized from the cover sheet of the analysis the findings?
A. As of December 1976 the sixty-eight people had been living at Pennhurst an average of 21.92 years. Programs reported by the superintendent included certain unstructured activities, such as free time and certain services such as public school and outside workshops, which were not provided by Pennhurst. Nevertheless, all entries for all programming were included in this analysis.

Many programs were reported without any duration or hours. These were not included. Approximately one out of eight programs had no hours reported.

The average time between the clients' admission and the first reported program with hours attributed was 18.8 years.

The total number of hours of programming reported by the superintendent for the sixty-eight people was 65,047 hours. The sixty-eight people have been at Pennhurst a total of 1,490 years; thus they are reported as having received 43.65 hours of programming per client per year. This translates to 7.2 minutes per client per day.

For the three years, with the programs with attributed hours, sixty-eight people were reported as
[8-186] having received 318 hours of programming per client per year. This translates to less than one hour per client per day.

* * *

Q. Dr. Hare, in the course of your work did you have the occasion to oversee a tabulation of the characteristics of persons on the waiting list for Pennhurst?
A. Yes, I did.

Q. And from what records were those tabulations made?
A. From the list of people on the Pennhurst waiting list since May of 1974, again provided by Superintendent Youngberg.
Q. Dr. Hare, I show you a document marked PARC Exhibit 55. Do you recognize that document?
A. Yes, I do.
Q. What is that document?
A. This is the waiting list representing a total of 2,328 persons.

Table 1 describes the level of mental retardation of the complete count. It shows that of the people on the waiting list, 20.3 percent fell into the mild range of retardation; 24.3 percent fell into the moderate range; 16.1 percent in the severe; and 7.8 percent into the profound range.

31.5 percent were listed as unmeasurable or unknown.

Table 2 is distribution of age on the basis of a sample of 700 persons on this list. 41 percent fell between the ages of birth and sxiteen; 17 percent be-
[8-187] tween seventeen and twenty; 23 percent between twenty-one and thirty-four; and 10 percent were older than thirty-five.

The approximate mean age of the persons on that waiting list was twenty years.

Table 3 denotes the current placement status on the complete count. 4.7 percent of these persons are at the present time in another Pennsylvania State Institution. 31.4 percent are in another facility, that is, a private licensed facility or a foster home, which would be Elwyn, Pine Hill Penncrest, and so on. 64 percent of them in number are at home or placement unknown.

* * *

[9-51] **Testimony of Winifred Halderman**

WINIFRED HALDERMAN, having been duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. FERLEGER:

Q. Mrs. Halderman, what county do you live in?

A. Bucks County.

Q. And how long have you lived there?

A. Since 1947.

Q. You are the mother of Terri Lee Halderman, —

[9-52] A. Yes.

Q. — the plaintiff in this case?

A. Yes, I am.

Q. When was Terri born?

A. July 29, 1953.

Q. Did you know at the time that she would be retarded?

A. Not exactly, no.

BY THE COURT:

Q. Is that 1963?

A. 1953.

BY MR. FERLEGER:

Q. At what point in her early development did you see any signs of anything abnormal?

A. In and around a year.

Q. I can't hear you.

A. Around a year.

Q. And what did you notice then?

A. Well, she just wasn't developing as fast as she should for a child of her age.

* * *

[9-57] Q. What occasioned her transfer to Pennhurst in February 1966?

A. The private home felt they could no longer handle her, she was getting too big.

Q. Was there any other community care to which they referred you?
A. No, there was not.

Q. When Terri Lee was transferred to Pennhurst was she placed on a ward with other residents who were able to walk or was she placed on some different sort of a ward?
A. In the beginning she was placed on a ward where they walked.

Q. And then what happened?
A. And then a short time later they said that Terri didn't adjust to that ward, so they moved her to the crib ward.

Q. And was she kept in a crib?
A. Most of the time, yes.

Q. Even though she could walk?
A. Right.

Q. Do you recall the name or number of that crib ward?
A. I am not sure, I think it was C-13.

Q. That would have been C-13 that she went to in March of 1966?
A. This would be it.

[9-58] Q. I note from the records and defendants' answers to interrogatories regarding Terri Lee Halderman that she remained there until about April 1970.

* * *

BY MR. FERLEGER:

Q. Will you describe what you saw, heard, felt, and observed on Ward C-13?

A. C-13 wasn't a very nice matter. It was very depressing. It smelled very, very bad.

Q. What did it smell like?

A. Urine and feces. There are just rows and rows of cribs with just barely enough room to get between.

There were many, many flies in there crawling all over the residents. They would crawl around their mouth and all over their body and a lot of them didn't have enough knowhow, how to get rid of the flies off of them, so they just laid there and they crawled all over them.

Q. Did the aides engage in any activities that you observed on that ward?

[9-59]

A. I never observed any, no.

Q. The aides didn't do anything about the flies, for example?

A. No. There were too many of them.

Q. About how many aides were on duty when you would visit?

A. I think there were usually around three, two or three.

Q. Were there any programs on that ward for Terri Halderman?

A. No, there wasn't.

Q. How do you know?

A. I never saw her in any activities at all.

Q. How frequently did you visit?

A. Usually once a week on Sundays.

Q. Do you recall whether Terri Lee Halderman suffered any injuries in that period of 1966 to 1970?

MR. GOLDBERG: Note my objection.

THE WITNESS: Not to my knowledge. I can't remember.

BY MR. FERLEGER:

Q. During that period was there any problem that you noted or that Pennhurst noted regarding Terri Halderman's weight?

A. Well, Terri Lee was quite thin. I don't feel she got enough to eat at Pennhurst.

Q. Let me just briefly read you some information and ask you for your response.

In response to Interrogatory Number 18 of the
[9-60] plaintiffs regarding Terri Lee Halderman the question was give weight and height of plaintiff on admission and weight and height at yearly intervals since admission.

The defendants answer:

No information regarding height, but this information regarding weight:

1967, sixty-five and a half pounds;
1968, sixty-three pounds;
1969, eighty-one pounds;
1970, eighty-one pounds;
1971, eighty-one pounds;
1972, seventy-five pounds;
1973, ninety-three and a half pounds;
1974, eighty-nine pounds.

Now how old was Terri Lee in 1966 when she went into Pennhurst, approximately?

A. Twelve years old.

* * *

[9-62] BY MR. FERLEGER:

Q. Did you make any complaints to any officials at Pennhurst regarding the weight loss that Terri Lee exhibited?

A. Yes. I spoke to Dr. Youngberg, Dr. Smilovitz, and I also spoke to Mrs. Cawley.

Q. Did Dr. Smilovitz or Dr. Youngberg, if you know, take any action to check whether or not she

was getting appropriate food or to check on her weight?

A. Yes. Dr. Smilovitz made them take a daily — I asked for a weekly weight check, but when he requested it he asked for a daily weight check on Terri's weight to make sure she is getting the proper amount of food.

Q. Did he say why he requested daily rather than weekly?

A. He said that way he knows that it is going to be taken care of every day.

Q. And did they find out whether or not she was getting the appropriate portion of food?

A. As long as they kept after them she got the appropriate food, yes.

Q. The responses to Interrogatory Number 1 indi-
[9-63] cate that Terri Lee went to Ward C-3 in May of 1970 after she came from and she remained on C-3 for certain hospitalizations until October 1971.

Could you describe Ward C-3?

A. C-3 was a ward that was on the first floor, a very large ward, another ward that was very drab, very smelly.

Q. What did it smell like?

A. Urine and feces.

Q. Did you see any urine on the floor?

A. Yes. There was urine on the floor nearly every time I went in.

Q. Were residents dressed or undressed?

A. Some were dressed and some were undressed, but they never had shoes and socks on.

Q. Was Terri Lee Halderman fully dressed?

A. Sometimes yes, sometimes no.

Q. When she had a dress on would she have been dressed in underwear or not?

A. Sometimes she'd have underwear on, underpants would be all; and other times, no, which was quite embarrassing.

Q. Embarrassing for whom?
A. My young son that went to visit with us.
Q. Did you ever complain about that?
A. Yes.
Q. Did things improve after your complaint?
[9-64] A. No.
Q. Now in the summer of 1971 did you have occasion, on C-3 to visit any resident who was lying on the floor?
A. Yes. That was around the time of my daughter's birthday and we had taken her out to Valley Forge Park to celebrate her birthday.

And when I took her back to her ward there was a resident sitting on the floor with her face down on the floor, in urine, so I brought it to the attention of an attendant who was there and she said yes, they —

MR. GOLDBERG: Objection.

BY MR. FERLEGER:

Q. And you brought that to the attention of patient-care workers?
A. Right.
Q. And did she agree with the facts that you observed?
A. Right.
Q. Did you ever speak to Dr. Youngberg about that?
A. Yes, I did.
Q. And what was his response?
A. Well, I told him about that and I also told him about the same resident that was on the floor with her face in the urine also went into the bathroom and ate the feces out of the john.
Q. What did Dr. Youngberg say?
A. Dr. Youngberg said that shouldn't be and he
[9-65] would see that condition was corrected.
Q. That was in 1971?

A. Right.
Q. I notice from the records that Pennhurst called Terri Lee Halderman a head-banger.

Now before she went to Pennhurst would she ever bang her head at home?
A. Well, Terri Lee is non-verbal and about the only time she would bang her head would be at night, when she had gone upstairs to go to bed. She'd go to the wall in the hallway and just give one bump, as if to say good night.

If she wasn't feeling well she sould bump her head to let us know that things weren't right.
Q. And then once you took action she would stop?
A. She would stop, right.
Q. She wasn't a constant head-banger so that she would get injured as a result of it?
A. No, no.

* * *

Q. What was the hospital's response to the head-banging?
[9-66] A. Well, they just said that she was a self-abusive child when they sent her home.
Q. Did you ever speak with Helen Francis?

I believe she is a nurse and a unit director.
A. Yes.
Q. Regarding the possibility of Terri's head-banging being the result of pain that she was experiencing?
A. Yes. There for a while Terri was banging very, very hard and often, and I was trying to get to the bottom of why she would be banging so bad because this isn't Terri's nature.

One of my questions was, you know, could she be starting maybe with her menstrual periods and, well, they didn't know.

Then I noticed she had a tooth broken off and I asked about the tooth and that was supposed to be taken care of but it wasn't done when it was supposed to be, and I thought maybe she was having pain in the jaw.

Q. And what did you discuss with Helen Francis? Those types of things that you have just mentioned?

A. Those things; right.

* * *

[9-67] Q. Did Terri Halderman have water available to drink on her ward as she desired?

A. There, I will put it this way. I spoke with them, both Miss Francis and Miss Cawley, and I believe Alex Mansfield on the water situation.

I was told by each one that there were water fountains, a large and a small one, on each of the units; but what they don't seem to understand is that most of the residents there don't know how to use the water fountain, so, therefore, they didn't get water.

Q. Did you ever see Terri Lee Halderman using the water fountain?

[9-68] A. No. She didn't know how to use the water fountain.

Q. Do you know if there were any programs in effect to teach her how to use a water fountain?

A. No.

Q. No, you don't know, or no, there weren't any?

A. No, I don't know.

Q. Were there any programs on C-3 for Terri Halderman?
A. Not to my knowledge.

Q. While she was on C-3 was Terri Halderman able to chew regular table food?
A. No. Terri chewed for just a short while when she was in a private home, but when she went to Pennhurst she lost her chewing ability again.

Q. Was she given table food or chopped-up food on C-3?
A. She was given table food on C-3.

Q. Despite the fact that she couldn't chew?
A. Yes.

This was another thing that I brought out about her head-banging. Perhaps she was suffering from the fact that she was swallowing her food whole.

Q. Did Terri Halderman receive any injuries to her fingers on April 9, 1971?

MR. GOLDBERG: Objection, your Honor.
This is probably the most leading question that he has asked.

[9-69] THE COURT: It is a leading question.
Let's talk about whether she ever injured her fingers.
Was that your question?

MR. FERLEGER: Yes, it was, your Honor.
Thank you.

BY MR. FERLEGER:

Q. Would you answer our collective question, please?

A. Yes. Terri Lee had three fingers broken in C-3.

BY THE COURT:

Q. Do you remember about when that could have happened?

A. Terri Lee had so many accidents, your Honor, in around this general time that I really — I really can't keep the dates in my mind.

Q. When would this be, approximately, when you said in and around this general time?

A. Oh, somewhere around probably '69 or '70; right on up until the time she left.

Q. And when did she leave?

A. A year and a half ago, October 30th.

THE COURT: All right. Let's proceed.

BY MR. FERLEGER:

Q. Do you know if the State Police were called in to investigate that injury?

A. Yes, they were.

[9-70] Q. And were you told or given any other notice by Pennhurst officials of the cause of her fractured fingers?

A. No. They said that they really didn't know for sure; they throught maybe she might have gotten them caught in the swinging doors but they had no proof of anything.

Q. Do you know if anything was ever done for those swinging doors on that ward?

A. I don't know. They were supposed to have been taken care of but I couldn't tell you.

Q. Did Terri Halderman at Pennhurst receive any injuries to her jaw?

A. Yes, she did.

Q. And about when was that?
A. That was, as I recall that was maybe six months after the broken finger.
Q. That would be in October 1971?
A. Right.
Q. Could you describe how you were notified of that injury?
A. Yes. I received a telephone call around dinner time that night.
Q. From whom?
A. I am not sure.
Q. And was that when you were notified of the injury?
A. That's right. They needed my permission to be able to operate the next morning.
[9-71] That was the reason for the call.
Q. Did they tell you what the injury was?
A. Yes. She said her jaw was broken.
Q. Did you see Terri Halderman in that state before the operation?
A. Yes. I called them back after I gave them permission on the telephone and asked them what time she was going to be operated on and they told me and I said please not to remove her to the operating room until I could see her. They told me eight-thirty.
Q. Could you describe in detail Terri Halderman's condition at the time you saw her?
A. Yes. Terri Lee is a small — is a small, little girl, very thin-faced; and when I saw her her face was ballooned out like this, and she was quite groggy and probably also was very uncomfortable at the time.
Q. Could you tell whether she was in pain?
A. From the look of her face, I would say yes.
Q. After the operation were there any difficulties in her recovering from the operation?

A. Well, right after surgery she had difficulty in coming out of the anesthetic.

* * *

[9-73]BY MR. FERLEGER:

Q. What did Dr. Wilton tell you?

A. He said that Terri Lee had too — well, was under too medication, too heavy medication.

A. And did he tell you what he would do about that?

Q. Yes. He told the nurse to cut down, in fact, to cut Terri Lee's medication cut that she gets ordinar-

[9-74] ily until he notified her; and also that the dose she was getting was entirely too large for the size of Terri Lee, and when she started to go back on it he started her on half the amount.

Q. Before you left to go home that day did you inquire as to the future care of Terri in recovering from that operation?

A. I had asked them — they had to restrain Terri because she would go back like this with her head all the time and her jaw was broken in three places, so they had to restrain her as much as possible so she wouldn't jar loose the wires.

So they used to take a sheet and twist it around her neck and around her arms and fasten it down so she couldn't raise up to come back.

And I asked them if they wanted to put the sheet on, and they said no, it wasn't necessary.

Q. And then did you leave?

A. Then I left, and I had forgotten something after I got to my car, so I had to go back into the hospital and that fast they had taken a sheet and fastened her down.

Q. You testified earlier about a tooth having been broken off.

How long did it take for that broken tooth to be repaired?

A. Well, I really don't know when the tooth was broken off because I was never notified of it.

Q. How long after you noticed it did it take for it to be repaired?

[9-75] A. It wasn't taken care of until the day her jaw was hurt and I asked the surgeon who was going to do the jaw if he would pull the piece of tooth out, and he said yes.

Q. And what was that period of time, approximately?

A. I am not sure. I'd say maybe around a year, a year and a half.

I am really not sure.

Q. But at least a year?

A. Yes.

Q. Were you ever asked by any employee or official at Pennhurst for permission for the hospital to administer drugs to Terri Halderman?

A. No. In fact, I didn't know for a long time that she was on drugs.

Q. Were you ever told of the effects of any tranquilizing or other psychotropic medication or the side effects?

A. No, I was not.

Q. Did you ever ask about whether she was drugged?

A. No, I didn't, not in the beginning, not until after I knew that she was on medication.

Q. How did you come to know that she was on medication?

A. When I received a letter one day from Dr. Parroco stating that Terri was in the hospital for listlessness and I called immediately to find out what was wrong, why she was listless, had she banged her head, was she sick.

[9-76] And I couldn't get any answer.

Q. You called and spoke to Dr. Norman Parroco?

A. I called and spoke to Dr. Norman Parroco.

Q. As far as you knew he was Terri Halderman's physician at the hospital?
A. That's right.
Q. Did you ever get to speak with him further on this issue?
A. I told him that day that I'd be up to the hospital the next day to see him, that I'd like to have an answer as to what was wrong with her.

And I went up the next day to visit Terri and as soon as I went there I told Mrs. Barto please get ahold of Dr. Parroco, I'd like to talk to him.
Q. Were you told that you could come to speak with him?
A. Yes.
Q. Then what happened?
A. Then Terri started to get a little unhappy and started to cry and they told her that I had gone downstairs with my young son, who had just got out of the hospital from ear surgery, so I went downstairs and told her to have Dr. Parroco come down there and I waited and waited and waited for about an hour and a half and no Dr. Parroco.

So I got on the phone and asked him to come over, but he couldn't come over.
Q. When you called did you speak with him?
[9-77] A. I finally got him, yes.
Q. And you recognized his voice?
A. Yes.
Q. Did he say he would come speak to you?
A. No, he wouldn't come talk with me. We talked on the phone.
Q. Did he explain to you why he wouldn't come to see you?
A. No.
Q. Did he explain at that point what he meant by Terri being hospitalized for listlessness?
A. After many, many minutes, he finally admitted

that she was in the hospital due to being over sedated with Mellaril.

Q. And what was your response?

A. And my response was I was quite angry because my young son at that time was on Mellaril and I asked him what did he know, an overdose of Mellaril? She had to have an awful large dose.

Q. In February 1972, according to the defendants' interrogatory responses, Terri Lee Halderman went to the New Horizons Building. Is that correct?

A. That's right.

Q. What ward was she on there?

A. 47.

Q. And was drinking water made available to Terri Halderman on that ward?

A. Only by the fountain. I brought — pardon?

Q. Go on.

[9-78] A. I had brought it to their attention also, to Miss Cawley, who was my social worker at that time, and she said the same thing.

* * *

BY MR. FERLEGER:

Q. Was Ward 47 a new or an old ward?

A. Ward 47 was a new ward. The New Horizons Building is the newest building there other than the modulars.

Q. Were toys made available to the residents on that ward?

A. They had toys, but they were kept in a closet.

Q. When you visited they were never out?

A. Very, very rarely. Once in a while the ball would be out.

Q. Was there the same amount of urine on the floor?

A. It wasn't as bad in 47 as the previous wards, but there was, yes, there was urine on the floor.

Q. And did the aides take any action to clean that up while you were present?
A. Yes, they did.
Q. Were there any injuries to Terri Halderman's toes in 1973?
A. Yes. Terri Lee had a broken — a broken toe in '73.
Q. Did you ever speak with Dr. Youngberg regarding the cause of the broken toe?
A. Yes. Several weeks before the broken toe
[9-79] Pennhurst was having a shortage of shoelaces and I brought it to the attention of Dr. Youngberg and he said yes, that the State had erred. The institution said the only thing they could order was food and medical supplies, so, therefore, they couldn't order the shoelaces.
Q. Do you have any idea from any Pennhurst officials regarding how Terri's toe was broken?
A. Yes. They told me that she had had —
MR. GOLDBERG: Objection, your Honor, unless she can identify who the declarant was.
BY MR. FERLEGER:
Q. Do you know who told you?
A. I don't know who told me all that.
Q. Were you given any information from Pennhurst which indicated to you that the broken toe was caused by a lack of shoelaces at Pennhurst?
A. Yes, because she didn't have the shoes one. She pulled a chair over on her foot.
Q. On Ward 47 — and we were talking now about February of 1972 until May of 1974 and later, until Terri Halderman was transferred from Pennhurst — were aides in constant attendance with the residents at all times?
A. No, they were not.
Q. Could you explain your answer?
A. Well, most of the time the aides weren't in the
[9-80] day room with the clients. They would either be in

the office or they might be showering someone; if they had had an accident or they may be socializing with someone in the back room.

Q. What number of residents would be left in the day room unattended?

A. Well, there were two day rooms. There would be maybe fifteen or twenty on each side.

Now one side was kept locked and the other side was open so the residents could go to the bathroom by themselves because they were trained.

Q. On the locked side would be residents —

A. Who were not trained.

Q. — who would be locked in the day room with no attendants present?

A. That's right.

Q. How many aides were on duty, either in the office or doing the other jobs you mentioned?

A. Usually two.

Q. Any times less?

A. Sometimes one, sometimes three.

Q. Did the aides have any housekeeping responsibilities as well as child-care responsibilities?

A. Yes, they did. They had to make all of the beds on the ward and on weekends they had to do all of the cleaning because there wasn't any cleaner come in on weekends.

[9-81] Q. Does Terri Halderman at this point in time have all her teeth?

A. No, she does not.

Q. Were her teeth pulled at some point?

A. Yes.

Q. Will you tell us when and why, if you know?

A. Oh, dear. Well, I can't remember the date.

They were pulled about six months after her broken jaw because they had to go back in and do some more work on her gum and at that time they pulled all of her teeth except the molar on the back of each side.

Q. Do you know why?
A. Why they pulled the teeth? Because most of them were rotten.

[9-82] BY THE COURT:
Q. Did you observe her condition after the operation?
A. Yes, I did.
Q. What did you observe during that period, —
A. Well, —
Q. — if anything?
A. There wasn't that much really to observe, except that the swelling did go down. There were no bruises of anything like that, but the problem was the fact that they had to go back in. See, the bone fragments had splintered as a result of the broken jaw and they had to go back in and remove the splinters and the bone fragments because they were afraid they would travel to either the ear or the brain and do more damage.

* * *

Testimony of F. J. Sobetsky

* * *

[9-147] Q. Did your children receive any injuries during the four or five years they were at Pennhurst?
A. Yes, they did.
Q. Would you describe how frequently they received injuries?
A. Well, Robert received injuries practically every week that he was there.
Q. How did you know?
A. Every time I brought him home he smelled so I put him in the bathtub and washed him; and you'd find bruises on him, bite marks on him, scratches
[9-148] on him, any part of his body, in fact, on his rump and on his back legs there were even some welts on them.

And I wondered at that time if he even got beat. I didn't know, but I know he had welts on there and I complained pretty frequently.
Q. You said that he smelled.

What did you mean by that?
A. Smelled from — I'd say smelled from the smell of Pennhurst.
Q. What kind of a smell would that have been?
A. Well, the urine or whatever smell that goes on there in that ward on in those wards.
Q. Did Teresa receive any similar injuries?
A. Not as many as Bobby. I will say maybe Teresa received about thirty percent of what Robert did.
Q. Do you know whether Dr. Youngberg, the Pennhurst superintendent, ever became aware of any of the injuries suffered by your children?
A. I am sure Dr. Youngberg was well informed from my letters of correspondence with him.
Q. Did you ever speak with him or did Robert ever confront him with anything?

A. Did I ever speak with Dr. Youngberg?
Q. About any injuries to Robert?
A. Yes, I did. I tried to get him out of his office one Friday at five o'clock in the afternoon and he didn't
[9-149] want to come out.
Q. Do you remember about how long ago that was?
A. I'd say within the last year and a half that they were there.
Q. And did Dr. Youngberg come speak with you that day?
A. After I told his secretary I was going to go up to the priest and that was the day that Robert was scratched up underneath his eyes, on his nose, on his cheeks, on his forehead.

And when I mentioned that I was going to go to the priest, then Dr. Youngberg did come out to the corridor and said, "Let's get Robert."
Q. He looked at Robert?
A. Yes, he did.
Q. What did Dr. Youngberg say?
A. He didn't say anything. He just says tssk, tssk; and that was about it and shook his head.
Q. Were there any problems with the dental care of Robert Sobestsky?
A. Well, he had a tooth pulled that I didn't even know the reason why it was pulled.

Robert's teeth are darn good. He had a darn good healthy set of teeth and they said he had it pulled.

When I come up to take him home that Friday, I had to wait for him and it was a pretty cold, bitter day, and the aide was carrying him down from the dental office to his ward.
[9-150] His mouth was all bloody. I guess the blood got all over his cheeks, all over his neck, so the aide just looked at me and said, "Don't blame this on me."
Q. Had you been asked for permission to have Pennhurst pull his tooth?

A. No.

Q. Do you know if your wife had been asked for permission?

A. No. My wife has never been asked neither.

* * *

BY MR. FERLEGER:

Q. Could you identify and describing generally what these pictures show?

A. Well, these are some of the conditions that Bobby came home with on weekends.

This one here has two big bite-marks on his back plus one on the back of his upper arm.

I think this is part of the condition when that youngster attacked Bobby in bed at two o'clock in the morning. This picture doesn't do it justice anyway; it was worse than that.

This is a different approach to the bite-mark.

Here is a big black-and-blue mark that oc-
[9-153] curred on his arm.

Here is another bite-mark on his back.

As you say, there never was any openings, but there is a picture saying that there was an opening.

Q. Now did you take these pictures?

A. I took those pictures, yes.

Q. Why.

A. Because Dr. Youngberg didn't want to quit — well, let's say, I can't say Dr. Youngberg, but at Pennhurst no one seemed to understand that the children weren't supposed to be put to this kind of treatment and I believe I notified them that I was taking pictures every weekend when something was wrong with the children.

Q. And what do these pictures represent from the same exhibit?

A. The same thing with Teresa. There is a big blue mark on her lip, on her lips, and a big bruise mark

here, and here is a picture where it shows that she fell and cut her chin, also the conditions after dental care — swollen lips, swollen jaws.

Q. And did some of these injuries happen after, as well as before, you filed the lawsuit in this case?

A. I don't believe I took any pictures after I filed the lawsuit. I just made some notations that I have at home in the book.

* * *

Testimony of Ruth Wood

[10-66] BY MR. RIVERA:

Q. Are you currently employed, Miss Wood?

[10-67] A. Yes, I am.

Q. Where are you currently employed?

A. With the Chester County Association for Retarded Citizens.

Q. What position do you hold?

A. Executive Director.

Q. What is Chester County Association for Retarted Citizens?

A. It is a non-profit agency operated by a board of directors which, in turn, are elected by the membership. It was incorporated for the purpose of helping mentally-retarded children and adults living in Chester County.

Q. Do you know who started it?

A. It was started by a group of parents and interested citizens in 1962.

Q. And the membership, what is that composed of?

A. Parents, professionals interested in the field of mental retardation, and friends interested in mental retardation as well.

Q. Can you tell us the purpose of the Chester County Association for Retarded Citizen?

A. The philosophy is to be interested in and help mentally-retarded citizens, wherever they may be, in an institution, living at home with their parents, in the schools.

We also work with our state and national associations in terms of having interest in legislation, issues, appropriations.

[10-68] Q. And does Chester County Association for Retarded Citizens — can I call that CARC From now on?

A. Yes.

Q. Does CARC run any programs for retarded citizens?

A. Yes, it does.
Q. Can you tell me what type of programs it runs?
A. We have a pre-school program for children from zero to three years of age and we have a group-living arrangement for group homes for retarded adults.
Q. What is the approximate age range of the citizens you serve?
A. In the community-living arrangement?
A. No, overall.
A. From birth to fifty-five.
Q. Okay.

And the level of retardation?

A. From severe and profound to mild.
Q. Are any of these citizens that you serve ex-Pennhurst residents?
A. Yes.
Q. You earlier mentioned that you are the executive director; is that right?
A. Yes.
Q. What are your duties as executive director?
A. They fall into two broad categories — one, I am
[10-69] the administrative head of the services we perform; and the other is the classic role of an executive director in NARC. It is to support the volunteers. It is a volunteer governing board that are my bosses, so to speak, and we are interested in extending the network of services, whether we do it ourselves or see other agencies do it, monitoring the services, working with the schools, and monitoring under the right to education, aiding parents in finding appropriate services for the children, public education on the field of retardation, study of issues, cooperation and prevention, research, work with other community agencies.

And then we, as I mentioned before, work with our state and national associations. You know, we have to raise money to do all of this.

Q. How did you become interested in the field of mental retardation?

A. I have a retarded daughter.

Q. Skipping the pre-school program, let's talk about the community-living arrangements.

Could you describe that for us briefly?

A. Our agency operates three different types of community-living arrangements or group homes.

One is called the long-term shelter and consists of a single residence or house with live-in staff.

The second, which for us is fairly recent, is
[10-70] clustered apartments, which consists of a series of apartments in a large complex, with staff living nearby but not with residents.

The third is minimal supervision, wherein living areas for the retarded individuals — and in our case two to an apartment or one to an apartment — live in the general geographic area and the staff live in that same area.

Q. Let's turn to the long-term shelter.

What is it? Does it have a goal?

A. The goal in a long-term shelter is perhaps for some people to be in a shelter for a long time. For others, it is to train individuals to move into another less-structured environment, and continuing service.

Q. How long has the long-term shelter program been in existence?

A. Our first long-term shelter began in the spring of 1973.

Q. Is one of these centers located in Coatesville?

A. Yes, it is.

Q. And what kind of location is it in — neighborhood?

A. It is in a residential neighborhood, large duplexes, and the house is a duplex which has been converted to a single residence.

Q. Could you walk us through this house, starting with the front door, please?
A. Okay.

As you come in the front door on the right is the
[10-71] apartment of the resident house manager. On the left is a large living room. Behind that is a dining room and then a kitchen, which is used by all members of the house, including the resident manager when he is on duty.

Directly in front of the entry there is a stairway to the second floor and on the second floor are the original bedrooms of the original two houses. There is no access to the second floor from the resident manager's apartment.

There are four bedrooms and two baths and then there is a converted room into a den.
Q. How many people live in this house?
A. Eight retarded residents from several places, and then the resident manager.
Q. And what are their levels of retardation?
A. From mild to moderate.
Q. And how much time do the residents spend within the group in the long-term shelter, let's say a day?
A. Except for the working hours, basically speaking, they are there during the evening hours; first thing in the morning, over the weekends unless they are involved with recreation or something of that sort.
Q. You mentioned during the working hours.

Are they involved in some kind of program of work?
[10-72] A. Yes. Currently all of them are occupied in the local workshop.
Q. And when do they go to the workshop?
A. They leave in the morning to catch a bus, public bus, about 8:15-8:30 and then return in the evening close to — a little after four.

Q. And they all take public transportation to get to work?

A. Yes.

Q. Does the group itself offer any kind of activities for the retarded citizens?

A. Yes. First of all, they have training in terms of learning living skills. They use goal planning and assess the individual as to where he or she might be in their skills and what needs to be done next.

Then, in addition to that, of course they are involved in learning to cook, learning to manage their own money, learning the care of the house, care of themselves and their clothing and so forth.

They learn how to shop and how to make use of the community in terms of recreation and things of that sort.

Q. Are these kinds of services around the group home?

A. There is no doctor assigned to the group home. They go to their own doctor, their own dentist.

They use the "Y". They also, in Coatesville they
[10-73] are fortunate enough in that there is a night-school program in the local high school, an adult school program that they can participate in. That's not true of all — in all of the centers.

Q. What kind of programs do they take in high school?

A. Well, some of them have to learn to read and write. Mathematical skills which will help them in the budgeting. Knowledge of the community or a little history — things of this sort, depending on the individual's needs.

Q. Are there any ex-Pennhurst residents in this home?

A. Yes.

Q. How many?

A. Five.

* * *

* * *

Testimony of L. Stuart Brown

[10-104]BY MS. CHRISTENSEN:

Q. Mr. Brown, how are you presently employed?

A. I am the Executive Director of the Delaware County Association for Retarded Citizens.

Q. And what is the general purpose of the Delaware County Association?

You don't mind if I refer to it as DELARC, D-E-L-A-R-C?

A. Fine.

Q. What is the general purpose of DELARC?

A. The principal purpose is to promote the general welfare of all mentally-retarded citizens in Delaware County and to provide services wherever necessary for those who are in need of services.

[10-105] Q. Could you briefly relate how DELARC fits into the organizational structure of the Pennsylvania Association for Retarded Citizens and then the National Association for Retarded Children?

A. Yes. We are one of fifty-eight affiliated chapters of the State association and the State association is a member unit of our national association.

Q. How many members does DELARC have?

A. We have 825 families in membership presently.

Q. How long have you been executive director?

A. Thirteen months.

Q. How was it that you became involved with DELARC and got the position of executive director?

A. I have a retarded daughter and that generated an interest in mental retardation. I served as a volunteer with the Montgomery County association and the State association and with the national association and about a year ago I was laid off from my

job at GE and knew of the opening in the Delaware County association and applied for it and got the position.

Q. Have you also held other offices within the state association?

A. Yes. I have held numerous jobs as committee chairman and I am an immediate past president of the Pennsylvania association. I also have been a director of the national association.

Q. What are your responsibilities as executive director of DELARC?

[10-106]

A. The responsibilities as executive director cover a wide range from fund-raising activities for the administration of day-to-day operation of programs and services for the mentally-retarded; engaging in advocacy functions; being a spokesman for the mentally-retarded when that is necessary; counselling parents and promoting the needs of the mentally-retarded to the community, to the general public; engaging in promoting of activities toward research and the welfare of the mentally-retarded in general.

Q. Is DELARC involved in any ongoing programs for mentally-retarded persons?

A. Yes. We are working in conjunction with Elwyn Institute to provide a pre-school program for approximately thirty-six youngsters in the community and we are operating three sheltered work-activity centers serving approximately 170 mentally-retarded clients.

Q. Are you now involved in any community-living arrangement projects?

A. We are not presently involved in community-living projects directly.

We do have several proposals and we have run a community-living arrangement in Upland, just outside of Chester, for approximately five years.

That operation was spun off to another agency as of July 1, 1976.

[10-107] Q. Does the Association for Retarded Citizens on the national or the local level have a particular philosophy regarding the types of programs that it sponsors?

A. We have — we have a philosophy of obtaining services rather than providing the service and that we are teaching other agencies to run the service rather than provide the service ourselves.

However, in areas of need, where a vacuum exists, DARC has stepped in and provided programs.

* * *

[10-109] Q. Could you describe for me the general purposes of the work-activities center?

A. The purpose of our work-activity centers in Delaware County is to develop the individual's ability to perform useful tasks, work tasks, and to acclimate to the work-world, coming to work on time, sitting at the workbench, and performing the operations that we have asked them to perform.

Q. After the stage of the work-activity center what is the next stage on the continuum of the employment-field training?

A. When we see a client in our programs that we believe is capable of being more proficient and carrying greater responsibility, we refer them to our part-time psychologist and an evaluation is made of the individual.

The parents are then contacted and recommendations are made from DELARC suggesting that the client be enrolled into the Bureau of Vocational Rehabilitation program and moved up into a higher level of work opportunity.

Q. In the period of time in which you have been di-

[10-110] rector or deputy director of DELARC have increas-

ing clients been referred to the Bureau of Rehabilitation?

A. Yes, quite a few over the years. At one time the Bureau of Vocational Rehabilitation worked directly with DELARC.

In recent times they have held their funds only for those higher-functioning individuals. As a result, we have referred the individual to the BVR program that is sponsored by the Elwyn Institute and some fifty clients — I believe fifty was the figure — have gone through our workshop and entered into the BVR program.

Q. Do you know where they go thereafter, after they have gone through the BVR program?

A. We have, since 1956, been serving retarded persons in Delaware County. We have had 310 enter our workshop. Presently 170 are still there; 138 have graduated.

Some are unknown; at this point we have lost track. Some have been employed in various businesses. I have a few — Two Guys employed a couple of retarded persons out in Delaware County. There is one young fellow working in a car-wash; one fellow is working for ITE Circuit Breaker Company, and two are working for the Federal Government. — one in the IRS and one in HEW. Several are working in the post office and have been there over ten years of steady employment.

We have others who are working in Gimbels and Wanamakers and nursing homes scattered around the community.

Q. Are there any limitations on the number of persons who can go through this cycle? [10-111]

A. DELARC itself does not have limitations on people entering into or traveling through the cycle except for the fact that we limited ourselves to those who are ambulatory and who have a potential of working.

We do have one young lady who is legally blind. We have one young man on crutches.

But they are all ambulatory to the point where they can get about and perform work functions.

The waiting list for entry into the work-activity program is maintained by the base service units and not by DELARC.

Q. Do you know whether the base service units now have a waiting list for persons who are ready to enter into the work-activities center?

A. Those records are not accessible to us, but it is our opinion that they have people in the community who are in need of work services, who could fit into our program.

Q. How are these DELARC work-activity centers funded?

A. The Delaware County Association is funded through two sources: we do our own fund-raising to a certain extent through special events — bike hikes and other fund-raising opportunities that we have as an association.

The main portion of the funding that we receive comes from the County Mental Health-Mental
[10-112] Retardation Administrator.

Q. Is there a continuum for the workers?

A. Yes. This year for the first time we are on a *per-diem* work based on the average daily attendance of our clients in the work program; and this is since January 1st of this year.

Q. For the purposes of describing one program, could you tell me, are all three work-activity centers essentially similar? If we were to choose one and talk about it, would it be similar to the other?

A. Yes. All of our work-activity centers are similar with slight variations.

Q. Could you describe briefly how the Lansdowne program functions?

A. The Lansdowne program operates on the basis that we have staff and facility provided by the County Mental Health and Mental Retardation Administrator; and on our staff we have a contract procurement specialist, who contacts businesses in the area to bring work into the shop for our clients to perform.

Q. And that contract procurement specialist is on the DELARC staff?

A. Yes, he is.

Q. How do workers arrive at the center?

A. Most of our clients are transported in private automobiles, either through car-pools or through friends who drive them to the program.

[10-113] We do have about one-third of the work force who uses public transportation. All of our facilities are located along bus lines and are readily accessible through public transportation.

Q. What type of contracts are being performed now at the Lansdowne center?

A. We have a variety of contracts. At any one point in time we may have two or three running simultaneously.

One of the more consistent contracts has been with United Airlines, where we are refurbishing the headset that's used on the airlines to give you music and watch the movies.

When they are used they have to be refurbished and repackaged.

We are doing a lot of packaging and small assembly work for Creed Plumbing Supply Company.

We have a lot of plastic tableware — knives, forks, and spoons — produced by Unique Industries here in Philadelphia that we are packaging for marketing on the supermarkets.

There is a variety of small packaging operations for Southco Industries, for example, using Allen

tees, mounting the Allen tees on a ring and packaging them for sale.

Q. Could you tell me what wage this facility is paying for this contract work?

[10-114] A. We have a minimum wage that we guarantee to all of our employees, whether they are productive or not. Therefore, each one of our clients goes home with a paycheck.

But for those who are productive we watch their production and keep track of how productive they are and pay them according to their productivity.

Again, we do not exceed half of the minimum wage allowance established by Wage and Hour.

Q. Do the work-activity centers provide additional services or activities for the workers at each center?

A. There have been a variety of extracurricular activities. There are socials put on by the Optimists Club; dinners that the clients come to; the recreation area from the YMCA providing programs for off-duty hours for our clients; the base service units in a couple of areas have been providing subject socialization programs from time to time.

Q. Do you know generally where the workers from the activities center reside?

A. Most of our clients reside at home with parents. We do have a few who are living in foster-home placement and a few who live in community-living arrangements who participate in our program.

Q. To your knowledge have any former Pennhurst residents participated in DELARC's work-activities center?

[10-115] A. Yes, we have had several.

Q. Could you recount an example or two of former Pennhurst residents who have worked in one or the other the DELARC activities centers? I would ask you just to use a first name instead of Mr. So-and-so, so we won't mention any specific client's name.

A. All right. Yes, I can think of two. We have eighteen presently in our program who are former residents.

Mr. Robert has spent some time at Pennhurst; is now in our work-activity program at Upland. He was somewhat of a behavior problem when he came out: has settled down partly due to the forceful parent that he is living with and partly we believe due to the fact that he has a daily work-program in our facility.

He is doing very well in the work that is assigned to him and coming along very nicely in our program.

Q. Coming on very nicely? Does he demonstrate any particular work skills that he did not have when he first came to your work-activities center?

A. As I indicated, he was a little kind of a behavior problem, kind of resistive to being told what to do instead of sitting down and addressing himself to the job that he was given.

He has now acquired those skills. He seems to have changed in personality to the extent that he is not the behavior problem that he has been; that he
[10-116] does perform the job that he has been assigned, and it looks as though he will be eligible for the BVR program in the near future.

Q. Would you have another example of an ex-Pennhurst resident who is also in your program?

A. Yes. Mr. Joseph spent some thirty-five years at Pennhurst. He is working at our Lansdowne facility. He was very aloof and quiet and reserved. He separated himself from the rest of the workers when he first came a year or so ago and in the short time that I have known him as a worker in the shop where my office is he has come out of his shell. He is beginning to address himself to the clients — to

his fellow workers — and carrying on conversations with them and with supervisors that we have.

There is definitely a change in his personality. He is capable of riding a bus and he is living now with his sister and his nephew, who is also in our program, a Down's fellow, who is in the home with him.

Q. Would you say that these two examples are typical of the type of growth in social and employment skills that workers in your program exhibit?

A. Yes, I would think so. Most of the clients who have come into our program are just like any other people coming to a new job — a little bit apprehensive and nervous about the fact that they are in a work program.

[10-117] With a little bit of tender, loving care from our staff we have been able to convert those clients into the program and make them feel important as workers.

Q. In this change, are there problems as time goes on with these programs?

A. Nothing serious. We have had occasional seizures and most of the clients who do have seizures are controlled.

We do have occasionally one of our fellows on public transportation take the wrong bus and end in a community where he didn't expect to be, but he has not had any serious problems in that regard.

Q. These clients carry identification so that those who take public transportation don't find it too difficult to get back?

A. Yes, most of them do.

* * *

[10-141] BY MR. GILHOOL:

Q. Mr. Brown, you testified that in fiscal year 1975 Delaware County returned some $16,000 in community-living arrangements funds to the State.

I show you PARC Exhibit Number 58. Do you recognize that set of documents?

A. Yes.

Q. What is that?

A. That is the documentation of funding returned or carried over by the Mental-Health and Mental Retardation program in the Commonwealth of Pennsylvania.

Q. The first page reports the unspent and returned-to-the-state funds for fiscal 1975, does it not?

A. That's right.

[10-142] Q. And next to Delaware County it says $15,566 returned from CLA funds?

A. Yes, sir.

Q. And $619 returned in community-living arrangements coordinator funds; is that correct?

A. That's correct.

Q. What does the second page show?

A. This is for fiscal year '73-'74. It indicates that Delaware County returned or carried over $12,332 in CLA funds and $1,979 in community-living arrangements funds.

Q. Since Mr. Cotton inquired concerning Montgomery County, what does it show for Montgomery County for funds returned in fiscal 1974?

A. Base allocation, Montgomery County returned $181,000; and in community-living arrangements, $41,000; and CLA coordinator, $4,000, for a total of $226,000.

Q. And for fiscal year 1973, what does it show in returned funds for Delaware County?

A. In Delaware County, you are all the way across.

In Montgomery County, $19,459 in group homes and $3,325 in CLA coordinator funds.

Q. And for fiscal 1975, the year for which you testified as to Delaware County, what does PARC Exhibit 58 show for Montgomery County returns?

A. For base allocation, $260,774; in CLA funds,
[10-143] $79,869; in community-living arrangements funds, coordinator funds, zero.

Q. And the five-county total for returned funds in fiscal 1975?

A. $1,612,760 in base allocations; $350,961 in community-living arrangements; $601 in community-living arrangements coordinator, $8,179 in family resource service money; and $178,992 in developmental disabilities money.

Q. You testified under Mr. Watkins' examination that one of the reasons in your opinion that community services had not been provided for Pennhurst residents was the failure of the defendants to deploy the *per-diem* spending at the institution in the institutional budget for use in the community; is that right?

A. Yes, sir.

Q. What is the *per diem* expenditure on community-living arrangements?

A. I cannot give you a good answer for all of them, but for the facility that we operated in Delaware County for fourteen individuals it ran about $7,000 per year per client, and I really can't give you a quick figure.

Q. That would be about $20 a day if my math is correct?

A. Whatever my math works out to.

Q. You worked at General Electric. In addition to community-living arrangements which provide the
[10-144] residential facilities, there need also be, if a Pennhurst resident is to live in the community, some funds for programs and activities in the community as well; is that correct?

[10-144] A. That's correct.
Q. At your workshop, by way of example, and your workshop provides activity for adults, does it not?
A. That's right.
Q. At your workshop what is the *per diem* cost of those activities?
A. About $11, $11.50 presently. We were on a sliding *per diem* scale according to the number of clients authorized into our program and at present it is around eleven fifty.
Q. Around $20 per day per person for residents and what was your figure?
A. About $11.50 — $12.00 per day.
Q. For the activities program in the community?
A. Right.
Q. What is the *per diem* cost at Pennhurst?
A. The last figures I saw were in excess of $60 — $65, I believe.
Q. Now you testified in response to the Judge's questioning that all of the expenditures of community-living arrangements were borne by State funds, did you not?
A. Yes, sir, I did.
Q. And those are the expenditures which provide both for the leasing or the purchase of the residence
[10-145] and for its operation day-to-day, year-to-year; is that correct?
A. Yes, sir.
Q. And those costs are borne entirely by the State?
A. Yes.
Q. Now what about the program service cost?

You testified a moment ago that in addition to residence, if Pennhurst people are to live in the community programs and activities must also be supplied in the community.

Now how was the cost of such programs shared? Are they borne by the State? Are they borne by the County? Are they borne proportionately?
A. As far as I know, it is on a 90-10 county-State

funding stream for those services — ninety from the State and ten from the county.

Q. So that your workshop activities, for example, while you received that from the county, that is composed of $9 originating from the State and one dollar originating from the county budget?

A. That's right; yes.

BY THE COURT:

Q. Do I understand then that if more community facilities are provided and approved for your particular county it means that the county's cost is going to increase?

A. That's right; not for —

Q. By ten percent that may be necessary for the
[10-146] programs; is that correct?

A. That's right.

BY MR. GILHOOL:

Q. For the 132 people who once lived in Delaware County, who now live at Pennhurst, is it correct that the State pays one hundred percent of the cost of services to them?

A. That's right.

Q. That is to say, the State pays both one hundred percent of their room and board-residential costs at Pennhurst and the State also pays one hundred percent of whatever services or programs or activities are provided at Pennhurst?

A. As far as I know, that's right.

BY THE COURT:

Q. Are you saying that the State pays then the approximate figure of sixty dollar a day per resident?

A. That's right.

BY MR. GILHOOL:

Q. So that the county must contribute funds if a resident is to live in the county, but the county needs not contribute any funds if the resident lives at Pennhurst?

A. That's right.

* * *

[10-148]BY MR. GILHOOL:

Q. Mr. Brown, has the Delaware County Association for Retarded Citizens, at least until Mr. Watkins suggested it in his examination of you a bit earlier, ever considered it the responsibility or the obligation or the role of the Delaware County Association for Retarded Citizens to provide and to operate community residence for all of the 132 people from Delaware County who now reside at Pennhurst?

A. No. We have never considered operating facilities to accommodate that many people.

Q. Whose responsibility, in your view, is it to plan, provide, and operate such facilities for the 132 people?

[10-149] A. It is my opinion that the Government has the obligation and responsibility to all of its citizens to provide the backbone of services and that private providers such as the ARC should be modest — rather than providers of the services that should be provided by Government.

Q. Mr. Brown, you were state-wide president of the Association for Retarded Citizens in the years 1973 through 1975, were you not?

A. Yes, sir.

Q. And since the late 1960s until the present you have been an active member of the Pennsylvania Association's small executive committee, have you not?

A. That's right.

Q. Would you, ever so briefly, tell us, name for us, the committees of the State association which you have chaired since 1969?

MR. WATKINS: What's the purpose of this?

MR. GILHOOL: The purpose of this is to lay the basis for further testimony. It is to establish his knowledge and testimony.

MR. WATKINS: Expert testimony?

MR. GILHOOL: No, sir. It is to lay the basis for his factual testimony and hence to establish the basis for his knowledge of a certain fact, certain things that happened and have not happened since 1969.

BY MR. GILHOOL:

[10-150] Q. Would you please tell us what committees you have chaired in the Pennsylvania association?

A. Yes. In September of 1968 I chaired the Education Committee for the State association. In 1969, I think about May or June, I was chairman of the Legislative Affairs Committee.

Q. And for what period of time, beginning in May or June of 1969; were you chairman of the Legislative Affairs Committee or PARC?

A. From May of '69 through to, I guess, the end of June in '72; somewhere in that vicinity.

I also chaired the Legal Action Committee on the right to education and various other organizational committees like Personnel during the time that I was involved and a member of the Executive Committee.

Q. In the course of your work then as chairman of those committees, as a member of PARC's Executive Committee, and the president for two years and the first vice-president in the preceding years, did you have occasion to participate in the effort to replace Pennhurst with community services?

A. Yes. In 1969 the association took on a much more militant approach towards the State care and we felt that we could move things much faster if we were to get into litigation in behalf of the mentally-retarded.

[10-151] One thing that we did pick up shortly after I became the chairman of the Legislative Affairs Committee was the capital budget projection in the Office of Mental Retardation for the ten-year period from 1969 to 1979.

We made an analysis of that proposal wherein it was intended to spend $17 million, $16.8 million, to fix up, to dress up, the old buildings at Pennhurst, build a new education building and a new administration building; and we looked at that $17 million as being a very large figure and we had to put it into something that had a meaning for us.

At that time you could buy a new home in my area of Montgomery County for about $28,000, and dividing $28,000 into $17 million, we could buy 607 houses.

If we took four residents from Pennhurst and put them in a house, a nice family setting, the whole 1900 residents at Pennhurst at that time would have been accommodated in 475 houses for an expenditure of about $13 million.

With the $4 million that was left over we could have bought $8,400 worth of furnishings for each one of the 475 homes.

With this analysis we apprroached the Legislature, talked to Senator Frame, had him amend a bill that he had introduced for the General State Authority, a multi-million dollar appropriations bill, in the area of Pennhurst, indicating that within the next years 900 residents were to be removed from
[10-152] Pennhurst and provided with a community-living arrangement and supportive services in the Southeast Region.

Q. And you participated closely in the negotiations which led to that piece of legislation?

A. Along with others in our association, yes.

Q. What happened thereafter?

A. Well, the State then took about six or seven months to hire in a man to develop the plan, how they were going to disperse 900 people from Pennhurst, and where those individuals would go.

Dr. Floyd McDowell made the plan, which now is GSA Project 523-1, Phase I, and took the records

of individuals, determined that they would need suitable different types of living arrangements to accommodate all of those 900 people; and indicated roughly where those people would be housed in the Southeast Region.

Q. Is this the report to which you have reference?

A. Yes, it is.

Q. This is the McDowell report?

A. Yes.

Q. Page one of the Act II sheet?

A. Yes, it was.

Q. And this record was completed by the 24th of March of 1971?

A. In that time frame, yes. I couldn't give you the exact date.

[10-153] MR. GILHOOL: It is, for the record, PARC Exhibit Number 24.

BY THE COURT:

Q. Who is Mr. McDowell, do you know?

A. Dr. Philip McDowell was hired by the Office of Mental Retardation.

Q. Of the State of Pennsylvania?

A. Yes, to develop this plan in their behalf. Other than that I am not sure of his credentials.

BY MR. GILHOOL:

Q. You testified, Mr. Brown, that in this report Mr. McDowell designed ten types of living arrangements for retarded people?

A. Nine or ten, whatever the figure was; that's right.

Q. Ten. Then he assigned all of the Pennhurst population to one or another of those nine types of living arrangements?

A. The 900 that he was considering. He was only looking at 900 individuals to move into the community and he developed those ten different types of homes for the very mild, almost independent-living

group, to the severly-retarded and medically-dependent individual.

Q. So that among them those nine types would accommodate the full range of disabilities represented in the Pennhurst population?

A. I would think so.

Q. And those nine types designed by Dr. McDowell
[10-154] became the basis for the seven or eight types of community-living arrangements under the Community-living Arrangements Program, did they not?

A. That's true.

Q. Now in addition to describing and costing the residential facilities for the 959 Pennhurst residents, the report also designed and costed service facilities as well, program and activity facilities, did it not?

A. That's right.

Q. And in addition it also identified what type of living arrangements would be necessary for the then additional 1,000 people who lived at Pennhurst, although it did not site them; is that correct?

A. That's true.

* * *

[10-155]BY MR. GILHOOL:

Q. This report finally also identifies the type of living arrangements for the then over 2,000 persons on the waiting list for Pennhurst, does it not?

A. Yes, it did.

Q. Now Mr. Watkins asked how long it would take you to prepare a plan and propose it for community-living arrangements and services in the community with 132 residents of Pennhurst who originated in Delaware County.

Your answer was a month, I believe?

A. That's right.

* * *

BY MR. GILHOOL:

Q. Is it fair to say, is it the case, Mr. Brown, that one of the reasons why you could prepare such a full set of plans and proposals for replacing Pennhurst in the lives of those 132 with services in the community — is it fair to say that one of the reasons that you could do that so quickly is because Dr.
[10-156] McDowell, in his Phase I report, did it for you fully six years ago?

A. Certainly. We would use the McDowell report as a base for the types of group homes.

I would also use the proposals that we already have where much of it is boilerplate requirement according to the guidelines and the program in that area just follows the difference in proposals generally, the differences in proposals generally is insignificant.

MR. GILHOOL: Thank you, Mr. Brown.

THE WITNESS: One further thing. I was talking about the community-living arrangements and not a full array of programs when I answered Mr. Watkins.

* * *

Testimony of Magdalen Bolin

[10-160] MR. RIVERA: The United States calls Magdalen Bolin.

MAGDALEN BOLIN, having been duly sworn, was examined and testified as follows:

BY MR. RIVERA:

Q. Where are you currently employed?

A. I am employed at Ken-Crest Center at 6224 Wissahickon Avenue, Philadelphia.

Q. And what position do you hold?

A. Residential program supervisor.

Q. And what are your duties as residential program supervisor?

A. I am responsible for the overall management of the house programming for the residents, training and supervision of the relief staff, and the physical operation of the house.

Q. Is that house at 6224 Wissahickon — is that the way you pronounce it?

A. That's right.

Q. — a community alternative home for mentally-retarded citizens?

A. Yes.

Q. Is there a name under which the home is known?

A. No.

Q. Is there a reason why this home doesn't have a name?

A. Because most community houses don't have names.

[10-161] Q. How many people live in this home?

A. Six boys and my husband and myself.

Q. What are the age ranges of these boys?

A. From nine to seventeen.

Q. Could you describe the type of neighborhood in which the house is located?

A. It is in the Roxborough section of Philadelphia, an old residential area. We live across the street from a park.

Q. I now hand you United States Exhibit 48, Pennhurst State School and Hospital photographs, and ask you to turn to page thirty-eight, pictures 73 and 74, and ask you whether that's an accurate representation of the house at 6224 Wissahickon Avenue.

A. Yes.

[10-162] * * *

BY MR. RIVERA:

Q. Looking at pictures 73 and 74, could you walk us through the house?

A. Okay. In 73, the house is a three-story duplex. It is on the corner of the street. You walk into the living room. The living room has a sofa, chairs, bench, aquarium, television, stereo; lots of plants, and a desk.

We have the kitchen behind that and the dining area behind that and a bathroom after the dining area.

The second floor has three bedrooms and a bathroom. Each of the bedrooms has a bed and each of the guys has his own dresser and mirror. They put their things in the room.

Each of the guys has either a television or stereo; book shelves, clock-radios — pretty much what you would see in any house.

Q. Is the whole duplex used? Do you occupy the whole duplex or just part of it?

A. We live on the left side of it.

[10-163] Q. Who lives on the right side of it?

A. A young woman.

Q. Is there a specific purpose for this house besides to live in?

A. It is to teach them to be able to cope with the living community.

Q. What would be known as an interim facility?

A. No, it is not.

Q. Is there a name for a group home?

A. It is a long-term sheltered children program.

Q. Are there any community support services available for the youngster?

A. Yes.

Q. What type?

A. We have the use of the local base service unit, which provides monthly program evaluations for the guys. It has provided individual counseling for the guys.

It has provided staff training for us, especially dealing with the emotional difficulties that the residents might have. We use the community guide services, of the dentist, local hospital, local speech therapist, and things of that nature.

Q. Do you offer a different type of program within the house?

A. Yes.

Q. What type of program?

[10-164] A. We have specific programs available which give the guys real preparation — housekeeping skills, laundry skills, self-care skills, sexual awareness — things pretty much which, you know, the things that they want in the community.

THE COURT: Let me interrupt you.

BY THE COURT:

Q. How old are they?

A. Nine to seventeen. We have one 9, one 14, three 15, and one 17.

Q. All boys?

A. Yes.

Q. You call them guys?

A. I call them guys.

Q. Do they like that?

A. Yes. The teenagers don't like to be called kids.

THE COURT: Guys? Okay.

BY MR. RIVERA:

Q. Are all the residents in some type of educational—

THE COURT: By the same token, do they call the girls dolls?

MR. RIVERA. I think that's the next witness, your Honor.

THE COURT: All right.

BY MR. RIVERA:

Q. Are all the residents in some type of educational program?

[10-165] A. Yes.

Q. What type of educational program are they in?

A. Four of them attend the high school, which is a special center for the training of the mentally-retarded students.

One of them attends Cook-Wissahickon School, which is a public school, which has special classes in K-8, and one of them attends Shawmont School, which is the same kind of a situation.

Q. How do they get to school?

A. Five of them go by school bus and one of them takes public transportation. He takes the SEPTA bus and then he makes a transfer and takes another SEPTA bus.

Q. Has he ever been lost?

A. No.

BY THE COURT:

Q. How is he getting to school these days?

A. By whoever is available to pick him up and take him.

BY MR. RIVERA:

Q. Do you have any ex-Pennhurst residents?

A. Yes.

Q. How many?
A. Two.
Q. Using just their first names could you describe them in terms of skill when they first arrived at the home?
A. Okay. Mr. Mario is now fifteen. He was twelve
[10-166] when he came to the house. He is still non-verbal.

When he came in he had severe behavior problems. He would do such things as eat newspapers and he would be ———. He would do these things also at school and we had several notes from the teacher that his behavior was uncontrollable and intolerable.

He had daily tantrums. He was biting or hitting and biting the kids, breaking furniture. He defecated in his pants and in his bed quite regularly.

You know, that's pretty much the major things.
Q. Did he experience any growth —
A. Yes.
Q. — while living at your home?
A. Yes.
Q. Could you describe in which ways he has grown and developed?
A. Well, he no longer defecates in his pants. His last report from school indicates that he was a model student, extremely cooperative.

He interacts with the other residents and the staff and the neighbors very well, even though he is non-verbal yet.

His school education has really improved. He is in a speech program at the house and he is beginning to communicate further.

[10-167] Q. Is that all?
A. Yes.
Q. What about the other ex-Pennhurst-resident?
A. That's Mr. Chris. He has the same kind of problem.

His behavior was quite a problem. He was very obstraperous around the house. In school he had frequent tantrums outside the house, using very loud obscenities. He messed his pants frequently. He ate the after he used them, and those were some of the major ones.

Q. Has he grown and developed?

A. Yes.

Q. Would you tell me in which ways?

A. In social skills, ability to communicate with other people. He doesn't have tantrums. He may use obscenities in the privacy of his room but not when other people are around.

That's pretty much it.

Q. Speaking of Mr. Mario, would you walk us through a typical day of his life?

A. He gets up around seven o'clock. He wakes himself up using an alarm clock. He gets up, makes his bed, gets dressed, using the bathroom, shaves, —

Q. How old is he?

A. Fifteen.

Q. And he shaves?

A. Well, he doesn't shave much but he likes to do it.

[10-168] And then, after he goes down and he makes himself breakfast; and depending on what he is having we might have to help him.

Q. Does everybody make their own individual breakfast?

A. They all do, yes. If they need assistance, if they are having something like eggs or bacon or something like that, —

Q. Is there one standard menu for all of the guys or do they all have different things at breakfast?

A. They all have what they want.

Then, after breakfast, he cleans up, puts the dishes in the dishwasher, and tries to get ready to go. He brushes his teeth and tries to get ready to go to school.

Q. Then he goes to school?

A. He goes to school, gets on the bus at twenty to nine.

He comes home from school at twenty to three. Then he changes into jeans, kind of does the laundry or whatever needs to be done around the house.

He might go outside to take a walk, go over to the park, play baseball, basketball.

And then help with the dinner, eat dinner. Then, after dinner, sometimes we go to the malls or something like that.

He does his speech program homework and then gets a shower and goes to bed somewhere between ten and eleven.

Q. Is this a typical day that the other children would be going through?

[10-169]

A. Pretty much typical. Each person pursues their own interests.

THE COURT: Let me just interrupt to ask a question.

BY THE COURT:

Q. The last young man that you talked about, the last guy you talked about, where was he before he came to your home?

A. Both of these two came from Pennhurst.

THE COURT: I believe you said that.

BY MR. RIVERA:

Q. Does Mario's schedule change on the weekends?

A. Yes. He doesn't go to school. We generally take — we generally are more active and we go to the Franklin Institute, movies, the Phillies game, up to the Poconos, the State park, climb fire towers, go in restaurants — pretty much what other people do.

Q. Who decides what to do on weekends?
A. Generally they decide what they want to do.

* * *

0-170] BY THE COURT:
Q. How are the costs of this community home provided, if you know?
A. It is through the State. The money goes through the County and then the County gets —
MR. SACHS: Louder please.
THE WITNESS: The money comes from the County, channeled through the County, I think, and I think the County disburses it to us.

BY THE COURT:
Q. How, as I take it, are you an employee, therefore, of the State?
A. No. I am an employee of Ken-Crest.
Q. Ken-Crest?
A. Yes, sir.
Q. Now tell me again. You did say that in the beginning, but who is Ken-Crest?
A. Ken-Crest is a non-profit organization serving mentally-retarded people and their families. They have a lot of other programs too.
Q. Do they have a lot of other programs in Philadelphia?
A. Yes.
Q. And how about in the other counties, if you know?
A. Yes.
Q. For instance, do they have a program in Chester
10-171] County, if you know?
A. Yes, they do have one.
Q. Montgomery?

A. They have three in Montgomery County and two due to open in a month.
Q. How about Bucks?
A. None in Bucks.
Q. None in Bucks?

And how long have you been employed by Ken-Crest — is it Ken, K-e-n?
A. Yes.
Q. How long have you been employed by them?
A. Almost six years.
Q. Six years?

And did I understand you to say you live there with your husband?
A. Yes.
Q. Is he also an employee?
A. He is a part-time employee. He has another job.
Q. Your husband has another job.

What does your husband do, by the way?
A. He is the director of a vocational rehabilitation program in Roxborough for young retarded adults, serving severely and profound mentally-impaired.
Q. And who employs him?
[10-172] A. He is employed by Intercommunity Action, Incorporated, which is our local base service unit.

THE COURT: All right.

MR. FERLEGER: I have a couple of questions, Judge.

CROSS EXAMINATION

BY MR. FERLEGER:

Q. When you need relief for taking care of the guys, what do you do?
A. We have four part-time staff people who cover for us.
Q. Do you like your work?
A. Yes.
Q. Why?
A. Because I like — I see a lot of progress in the

guys and I think it is very good for them to live and it is good for me too.

Q. Did you ever work in an institution like Pennhurst?

A. I haven't worked at Pennhurst but I worked for a short while at Ken-Crest Residential Center in Mont Clare.

Q. And is this sort of program you are working in now more satisfying to you as a worker?

A. Yes.

BY THE COURT:

Q. Let me just ask you, what is your educational background?

A. I have a Bachelor's degree in History from Temple University and I have had a minor in Psychology and some graduate experience in Social Administration.

[10-173]

* * *

BY MR. LASKI:

Q. When you described the behavior of the residents of your home who came from Pennhurst, you said that they exhibited abusive behavior or intolerable behavior, got reports from the schoolteacher and so forth, and eventually they made progress to where their behaviors were quite good.

Could you describe to the Court what types of programs and what types of efforts and activities you engaged in to bring about this growth in development and behavior?

A. Basically, the attitude of expectation, and I find that people generally come up to the expectations that you have of them.

The guys all like to live in the community, they all like living in a group home.

They really didn't like living at Pennhurst and I think that they were eager, willing, and ready to

change and we provided an atmosphere for them to change; and they did.

[10-174] This is a program that we all believe in the philosophy of normalization and treat the guys like kings and when we treat them like kings we find that they act that way.

MR. LASKI: Fine.

BY THE COURT:

Q. What did you say to these teenagers that would, as you say, mess in their pants?

A. We really didn't say anything. We found it is much better to praise them when they do good things than to punish them.

Q. Is it your testimony, therefore, that they learned to adapt to their surroundings and didn't do that anymore?

A. True.

Q. How long did that take?

A. With one of the guys it took about six months; and with the other guy it took about a month.

THE COURT: All right.

Thank you.

* * *

Supreme Court, U.S.
FILED
OCT 30 1980
MICHAEL RODAK, JR., CLERK

Nos. 79-1404, 79-1408,
79-1414, 79-1415, 79-1489

IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1980

Pennhurst State School and
Hospital, et al.,

Petitioners

v.

Terri Lee Halderman, et al.

Pennsylvania Association for
Retarded Citizens, et al.

and

United States of America,

Respondents

**ON WRITS OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT**

JOINT APPENDIX
VOLUME IV, A695-A812

**Petitions for Certiorari Filed March 12 and 20, 1980.
Certiorari Granted June 9, 1980.**

THE LEGAL INTELLIGENCER, 66 NORTH JUNIPER STREET, PHILA., PA. 19107 (215) 561-4050

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**Qualifications of expert witnesses were stipulated pre-trial, Curriculum vitae designated as PARC and US Exhibits, detailing education, experience, publications and other qualifications of all plaintiffs' witnesses are found in the Final Pre-Trial Order filed at R. 464, March 31, 1978.

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Testimony of Jeanne Hight

[11-15] MRS. JEANNE HIGHT, having been duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. STUTMAN:

Q. Mrs. Hight, you are the mother of a retarded child?

A. Yes, I am.

Q. And what is your child's name?

A. Robert.

Q. And he is one of how many children?

A. Seven.

Q. And what is the age range of your children?

A. On to Robert is 12.

[11-16] Q. Is he the baby?

A. Yes, he is.

Q. When was he born?

A. June 7, '65.

Q. Was he retarded at birth?

A. No, he wasn't. He had encephalitis.

Q. At what age?

A. 11 months.

Q. And as a result of that illness is he now disabled?

A. Yes, he is. He is severely disabled and paralyzed on his left side.

* * *

[11-17] Q. When was the first time you sought the assistance of the County Mental Health and Mental Retardation Administration?

A. In 1970 we were told by Dr. Gelman to look for some place to put him; and I went to the Mental Health Unit to put him on the list for Pennhurst because that was the only alternative I had.

Q. In which county did you reside in 1965?

A. Delaware County.

Q. Do you still reside in Delaware County?
A. Yes, I do.
Q. When you sought the assistance of the County authorities, what place did you go to?
A. We went out to Media, to the Mental Health.
Q. At that time in 1970 what were your expectations for your child, Robert? What did you expect he was capable of learning and doing?
A. Well, from what I was told by the doctors, he would never get any better but, of course, I never gave up hope.
Q. In 1970 you said you went to Media.

What did you do in Media besides put him on the waiting list?
A. That was all. We put him on the waiting list because I didn't want to leave him with my other children. It was just like taking out insurance.
[11-18]
Q. Were you concerned about the future in the absence of both you and your husband?
A. Yes.
Q. At that time were you advised by anyone in the County Office that there was a community program which could reach or meet Robert's needs?

MR. WATKINS: Your Honor, may I ask that the witness not be led throughout the entire testimony?

MR. STUTMAN: I will withdraw the question.

BY MR. STUTMAN:

Q. Did you know of any community alternatives at that time?
A. No, I didn't. I don't think there were any.
Q. Was Robert in school between 1965 and 1970?
A. No, he wasn't.
Q. When he became five years old did you try to enroll him in the public schools?
A. There were no schools that would accept the child as severely handicapped as he was.

Q. What was the date on which Robert ultimately entered Pennhurst?
A. Pennhurst?
Q. Yes.
A. That was three years ago. He went in —
Q. Might I refresh your recollection by suggesting it was in September of 1974?
[11-19] A. Yes.
Q. Does that sound about right?
A. Yes, it was.
Q. Between 1970 and 1974 where did Robert reside?
A. At home.
Q. During that time did you have any contacts with either the County office in Delaware County for mental health and mental retardation or your local base service unit?
A. No, I did not. No.
Q. During that time did the County office or the local base service unit provide you with any respite care?
A. No, none at all.
Q. Did they provide you with any other kinds of support services which would have been useful?
A. No.
Q. What happened in 1974, if anything, which intensified your needs for some assistance with Robert?
A. Well, my husband had a heart attack.
Q. And when was that?
A. That was in February, '74.
Q. And how did that complicate the home situation for you and your family?
A. Well, he was disabled. I had him to take care of plus five other children living at home; and it was impossible.
[11-20] Q. How did Robert get around the home?
A. He crawled.

Q. After your husband became ill did you take any steps to gain assistance from any County office or base service unit for your family?

A. Well, there weren't any services that would do me any good.

Q. There was a hearing, wasn't there?

A. Yes, yes.

Q. At that hearing who attended besides yourself and your husband?

A. There were two people from the base service unit.

Q. Do you recall who they were?

A. Larry Kashi and Mrs. Moffa.

MR. WATKINS: Can we learn when that was?

BY MR. STUTMAN:

Q. That was in August of 1974?

A. Yes.

* * *

[11-21] BY MR. STUTMAN:

Q. At the hearing do you recall any discussion about where Robert could reside other than at Pennhurst?

A. Well, there was no other places available. They were all filled up.

Q. Do you recall the day when Robert went to Pennhurst.

[11-22] A. Yes, very well.

Q. Could you describe that day?

A. Well, we took him up, my husband and I and my daughter, and he was put in a unit. I don't recall the number of it.

There were about 45 other children in it.

Q. Had you been to Pennhurst before?

A. We had been once before.

Q. And did you have a tour?

A. Not exactly. They showed us just like the dining area, where they would eat.

Q. When was the next time you saw Robert following his placement at Pennhurst?
A. Two and a half weeks later.
Q. What was the purpose of your visit to Pennhurst?
A. We went up on a Saturday morning to bring him home for the weekend.
Q. Could you describe Robert's physical appearance at that time?
A. Well, he was black-and-blue. There was a black-and-blue on his back. His mouth was all cut and he was heavily drugged. He didn't know me.
Q. Did you take him home for the visit as planned?
A. Yes, we did.
Q. Did you bring Robert back to Pennhurst?
A. No, I never did. He is still home.
[11-23] Q. So he was at Pennhurst a total of two and a half weeks?
A. Yes.
Q. When you were picking up Robert that day did you observe anything about the ward itself?
A. Well, there were approximately 25 children walking around naked and there were others that were partially dressed.
Q. Why didn't you bring Robert back to Pennhurst?
A. Well, my conscience would bother me.
Q. In what way?
A. I wouldn't leave a dog in conditions like that.
Q. You mentioned that Robert was heavily drugged.

Can you describe what indicated that to you?
A. Well, he could crawl before and he couldn't. This is two and a half weeks later.

He couldn't sit up. He couldn't hold his head up, and I took him to the doctor because of the bruises on his body.

It took at least a week for the drug to wear off that he could even sit.

Q. Was he able to do, after you took him home, the things that he could do prior to your putting him in?
A. No, he couldn't.
Q. Robert is presently at home?
A. Yes, he is.
Q. What kind of things would you need from the
[11-24] County and the base service unit to support you and your family in raising Robert?
A. Well, an occasional babysitter. My husband and I never go on vacation. We never go out. It is impossible; we can't.
Q. Have you had occasion to ask for a babysitter recently?
A. My grandson made his first communion two weeks ago and I called them for a babysitter.
Q. Whom did you call?
A. Larry Kashi.
Q. Is he in the base service unit?
A. Yes, he is.
Q. And what were you told?
A. That service is no longer available.
Q. Have they provided you with any visiting nurses or services?
A. No, no.
Q. Any homemaker services?
A. No.
Q. What is Robert's present status with reference to Pennhurst?
A. He is on a three-year leave of absence.
Q. Do you know what that means?
A. It will be up in September.
Q. What does that mean?
A. That means he either goes back or he has to re-
[11-25] port to me again.
Q. In other words, within three years Robert can go back to Pennhurst at any time?
A. At any time, yes.

Q. At the expiration of three years he is taken off the waiting list?
A. Yes.
Q. Taken off the roll?
A. Yes.
Q. What kind of services would you want in Delaware County for Robert?
A. I would like a place in the community that would be close and equipped to take care of a child like him.
Q. A community residence?
A. Yes, or he could live at home if I had some help.
Q. Could you describe the type of help you would need to have Robert living home with your family?
A. Well, just as I said, I would have liked to have gone to my grandson's first communion but I didn't.

* * *

[11-80] **Testimony of R. Kulp**

* * *

A. He went to the apartment cluster first.
Q. Can you describe any growth or any changes that you observed and are aware of in Wayne during this period of time that he has been at the apartment cluster?
A. We worked on socialization, his money-management and budgeting concepts, his banking skills; also, his maintenance and personal hygiene, his dress, his mannerisms, also enabling him to continue in his employment.

He has also been going to night school, taken a couple of courses in elementary mechanics offered at the night school, besides academic areas.

He is presently taking — he has a learner's permit and is getting ready to take his driver's examination and he is also preparing right now to move out of our program into an independent apartment structure with three of the other men or two of the other men in the program.
Q. Do you know how long Wayne was at Pennhurst?
A. 17 years.
Q. Do you have any other examples of any other residents living in the apartment cluster from Pennhurst?
A. We have had another fellow named Russell, who has done reasonably well too at the program. He is doing many of the similar things that Wayne had learned in the areas of socialization, money-management, preparation of food.

Also, you know, the making up of shopping lists
[11-81] and purchasing of the various items.

He has also participated in our programs in survival skills; also gone to evening school and secured

a job at the Holiday Inn, which he has held for about the last 18 months.

He has done real well. He works as a night janitor there.

Q. How long was Russell in Pennhurst?

A. 35 years.

Q. And the type of skills that you described, are these skills that he had when he came out of Pennhurst?

A. No, he did not.

* * *

Testimony of Ronald W. Conley

* * *

[11-93] MR. LASKI: Your Honor, Dr. Conley is qualified as an expert in the economies of services to the mentally-retarded, the sociology of mental retardation, the economic and political determinants of public policy and services for the retarded, and planning evaluation, social welfare and human services programs in the United States.

DIRECT EXAMINATION

BY MR. LASKI:

Q. Dr. Conley, did you undertake a complete study of the economics of services to the mentally-retarded?

A. Yes.

* * *

[11-95] Q. What were your findings in respect to your analyses of the several epidemiological surveys of mental retardation and demographic characteristics of mentally-retarded persons?

A. In looking at the epidemiological studies that existed at the time, the one thing that was very striking is that none of them agreed with each other.

* * *

[11-96] When one begins to adjust for all of these various factors one could begin to develop considerable amounts of agreement among the various studies and, in fact, ultimately I concluded that the estimate of mental retardation was about three percent in the population, which was, surprisingly, the figure that had been used for a very long period of time.

This comes out to about 5.6 million people, of whom the vast majority were what were called mentally-retarded and IQs say between 50 and 70, the vast majority, by 88.2 percent.

Another 8.3 percent were what were normally regarded as moderate; and severe retardation with an IQ under 50, and the remainder or a very small percentage were profoundly retarded with an IQ of below 25.

* * *

[11-97] I think it should also be pointed out that this estimate is the summation of many separate prevalent rates. For example, we found much higher rates of mental retardation among the poor and the Whites and the three-percent figure is sort of the weighted average of these various prevalent grades.

Q. What did you find in terms of the numbers of people of that 5.6 million who are in institutions throughout the country?

A. The majority of mentally-retarded, of course, live in the community and they always have lived in the community.

Of the 5.6 million we estimated that in 1970 only about 270,000 were in some sort of full-time residential care. The majority, about 186,000, in public institutions for the mentally-retarded, such as Pennhurst.

This is based on data that we were able to accumulate from the American Association of Mental Deficiency, which did a survey that year on the institutional population; information from the National Institute of Mental Health, which conducted a survey for that year; plus information from the massive facility inventory from the National Center for Health statis . . .

* * *

[11-98] Q. Dr. Conley, given that most mentally-retarded persons do live in the community and have lived in the community and only a few are in institutions, can you explain why persons are placed in institutions such as Pennhurst?

A. Up until again very recent years most parents really had only two alternatives. The most retarded person had really only two alternatives.

Either the person could remain at home with their parents —

I take it back. Make it three alternatives.

If they were a child they could remain at home with the parents. If they were an adult they could

[11-99] somehow live independently or they could go into institutions which provided basically full-time total care.

There was not the range of alternative-care facilities that were desperately needed in the community. Lacking these alternative facilities that provided lesser degrees of supervision than a public institution, if they could not be kept at home, then, indeed, they would have to be placed in an institution and there were many, many circumstances that would arise that would prevent a retarded person from being kept at home.

In those days, lacking adequate public or community services for the retarded, parents would have no relief from what would amount to daily, 24-hour-a-day, constant attention that would have to be paid to children.

If the family lacked its own resources to get adequate services, lacking respite care with other children in the family, then frequently an institution seemed to be the only way to obtain relief.

This was made apparent from the fact that of the retarded persons in institutions in 1970 —

THE COURT: Could I interrupt and ask you a question?

BY THE COURT:

Q. I am not sure that you gave me the number. How many retarded did you estimate were in institutions in 1970?

A. 270,000.

[11-100] Q. 270,000?

A. Right.

Now let me qualify that — 270,000 in residential care, of which about 186,000 were in public institutions for the retarded; another 30,000 were placed in public mental hospitals; and say another 30,000 from private institutions for the retarded.

And then a small number placed in other types of facilities, and we even include the few thousand in prison because in some parts of the country that seems to be one way of institutionalizing the retarded.

Q. Dr. Conley, did you have any figures which would indicate what percentage of retarded persons at each level of development were in institutions and what percentage were living in the community?

A. Yes. In 1970 we estimated that one third of the profoundly-retarded, one fifth of the moderately-to-severely-retarded, and only one fiftieth or two percent of the mildly-retarded had to be placed in institutions.

Q. Is it your testimony that one third of the profoundly-retarded were in institutions and two thirds were living in the community?

A. Yes.

* * *

[11-103] BY MR. LASKI:

Q. Dr. Conley, what type of services does a mentally-retarded person need?

A. The mentally-retarded basically need the same types of services that anyone else needs and they basically have the same goal.

In providing services one wishes to develop their intellectual skills, their physical skills, their cultural and their vocational skills.

The only difference that one finds between the mentally-retarded and a so-called non-retarded person is that the mentally-retarded may take additional services. They may take them in somewhat modified form. Their development may be somewhat slower and a little less complete than those of other individuals; and of adults; those who are more severely retarded will certainly need some form of supportive care, and by "supportive care" let me emphasize I don't necessarily mean 24-hour-a-day care, but some degree of support.

[11-104]

Q. Do the retarded require that these services be provided separately and away from other services to the general population?

A. Let's again take a quick view as to what services we are talking about because they require, as I said before, the same things that anyone else requires. They need to be educated they need to be provided medical care, they will need counseling and as adults they may need some modification of the work and cultural environment in order to function properly.

For the most part these services can be provided in the same setting as for anyone else. You know, in education, we have special education classes in the public schools and for those who are less severely retarded, with special help, they can frequently be integrated right into the classroom. Medical Care, there is almost no classification for providing it separately from a non-retarded person.

Work, the vast majority of mentally-retarded do work in what I call regular employment settings.

[11-105]

In fact, setting up separate services for the mentally-retarded can be very expensive, prohibitively expensive, in fact.

Can you imagine setting up an institution serving 1200 or 1500 persons, a medical facility of the type of quality that one can find in a major city like Philadelphia? It simply can't be done.

Q. But are there not economies of scale in large-scale institutions for the mentally-retarded?

A. Economies of scale is a very difficult term to justify when one really begins to look at institutional care.

To begin with, caring for the mentally-retarded in institutions is what we call a labor-intensive industry. It takes people and people can only serve so many people and once you get beyond serving a certain number of people you are going to increase staff at the same rate that you increase the resident population, which means that there will be very few economies of scale. Costs will increase roughly in proportion to population.

As a matter of fact, it is my belief that in many institutions there are very substantial diseconomies of scale because if you look in institutions that are placed, as many of them are, out in the country and one attempts to make self-contained units out of
[11-106] them, they are institutions that have their own water supply, their own power supply, their own mortuary, their own cemeteries, their own medical facilities.

They are providing these things on a very small scale and relative to the cost of getting these same services in an urban environment, as we all know, the water bill is a flat rate, what has to be paid for in an institution is very expensive. In other words, it is like a very small city; it is extremely inefficient.

Empirically, I looked in 1970 at about 150 residential facilities, that is, 150 institutions, which was the vast majority in the country of any size; and based on digress analysis and scatter diagrams I be-

gan to compare population sizes and costs and found that there were almost no economies of scale once the resident population got over 500. Now that was empirical work and that empirical work is very suspect because economies of scale probably don't exist up to that size.

For example, in looking at residential facilities as a unit, as we did, we assume that the same type of services were appropriate for all the residents of that facility, which is manifestly untrue. A mildly-retarded person who requires some type of supervision can live in the community with far fewer services than institutions provide and economies of scale for this type of retarded person would be far smaller. It would be a much smaller facility that would be appropriate.

One should also consider another factor, that in
[11-107] addition to looking at costs one should always look at the quality of care, and large institutions frequently have low costs because the quality of care that is provided is often very low. Residents are crowded into wards, relatively few developmental services are provided, and looking at these facilities on the basis of cost alone, without looking at the quality of care that is provided, it is very expensive.

Q. Even if there were some economies of scale, are there some compensating advantages to small-scale residential facilities in the community?

A. I believe that there are a number of reasons why there may be major advantages to having community facilities for the mentally-retarded.

To begin with, I think there are several reasons why one would have lower costs. One relates to this notion of economies of scale.

If you put facilities in the community then the facilities can purchase services at community rate. They can purchase water at the regular rates of the

water company. They can purchase power at the regular rates of the power company. They purchase medical care from the local hospital and all of these various services that the facility will obtain should be considerably cheaper than that provided in an institution.

The second reason why small facilities in the community should be less expensive than large
[11-108] residential facilities is that small facilities curtail the services to meet the needs of a particular group of the mentally-retarded. Take a large facility like Pennhurst. It basically is limited to providing 24-hour-a-day care —

* * *

THE WITNESS: In terms of lower costs, given that public institutions in general provide 24-hour-a-day care, total care, small facilities which are the
[11-109] alternative can be specialized where you only provide that amount of care needed for specific groups of the mentally-retarded; and to provide only that amount of care, the cost of providing services should be very much less.

The second and very important point is that in addition to lower costs, there are substantial benefits to placing the mentally-retarded in the community rather than in a large institution.

For one thing, placing the retarded in community-living arrangements makes it possible to keep the mentally-retarded closer to home and maintaining community ties is considered very beneficial.

Even more important, placing the mentally-retarded in the community makes it possible for them to seek and obtain employment, employment that can be very remunerative and rewarding both to the mentally-retarded and to Society.

I concluded in 1970 that the economic argument in favor of small community-based living ar-

rangements for the retarded were very strong and that the social benefits to Society would be very great.

At that time I thought they would be as high as $8,000 per person, considering what you would save in terms of rationed institutional costs and what the retarded would be likely to earn in the community. Since then the potential gains have increased remarkably.

[11-110] Q. You mentioned one benefit of small-scale facilities in the community is the ability to locate work in the community settings.

Do your studies indicate that retarded people have work skills and are capable of employment?
A. One of the surprising things that came out of the work that I did was that we concluded that the mentally-retarded have very strong vocational potential. I think then and even now one frequently sees that there is kind of an underlying assumption that if a person is mentally retarded they will be incapable of substantial work; or if they are capable of work it is very likely to be in a sheltered workshop at relatively low wages.

Now I looked at 27 follow-up studies of the mentally-retarded, which was all I could find, and, indeed, I found in those studies that the rate of employment among the mentally-retarded was very low and that earnings were very low.

Now the fault was not among the mentally-retarded. The fault was among the analysts because the analysts were not examining the data very carefully, because when you begin to go back and look at some of the demographic characteristics of the retarded, whose earnings were low and whose employment was low, one found that almost all follow-up studies were conducted shortly after the mentally-retarded left school and their age range tended

to be 15, 16 and 17. Yet their earnings were low, but so were those of all 15-, 16-, and 17-year-olds.

[11-111] When one begins to examine these studies carefully and begins to look at the age-earnings profile over time then one came to remarkably different conclusions. There were, fortunately, some studies that did follow up studies of the mentally-retarded into the middle age of the mentally-retarded cohorts and what I concluded — and this is based on studies, fine studies that were done in Connecticut and Iowa — were that among the mildly-retarded, and I emphasize this is the vast majority of the retarded, that males had employment rates, and I mean actual work rates of 87 percent, which was only four percentage points below the employment rates of the general population.

Even more surprising, I found that their earnings were about 86 percent of the average, which meant that from a vocational standpoint the success rate was very high.

Among women the employment rates for the mildly-retarded were 33 percent, which at that time was about 12 percentage points below the average for women in the United States.

This does not mean that they were vocationally unsuccessful because we found that many mildly-retarded women that were married simply chose to be homemakers rather than to go into the work force.

This is a very difficult field for the retarded that generally existed before and I am afraid exists in many people's minds at the present.

Q. Dr. Conley, does that apply to just mentally-re-

[11-112] tarded persons who are in the community or are mentally-retarded persons in institutions also capable of employment?

A. These follow-up studies were done almost en-

tirely — well, they were done entirely on the mentally-retarded in the community.

There is no reason to think that the mentally-retarded in institutions would have significantly worse work potential.

I have been very impressed by at least one study done in Pennsylvania of Polk State Institution that indicated — this is before the peonage act, so we no longer allow residents to work — but at that time, at least, one in two adults in the institution worked on institutional activities and what was even more interesting was that the majority of those who were in the institution working were in the moderately-severe mentally-retarded range. As a matter of fact, the number of mentally-retarded residents who were working outnumbered those who were paid by a ratio of two to one, so there is no question that they were found capable of work.

In point of fact, it is difficult — let me back up a minute.

The question that they can work is well established because we see them working. The question of whether they can find meaningful work is a more pertinent one because it is very difficult to find
[11-113] meaningful work for all the residents in a large institution on institution grounds, and I do not regard sheltered workshops in general as providing meaningful work.

Firstly, if you place a thousand, 1500, 2,000 residents in an institution in the country, without providing the transportation to an urban area, it is manifestly impossible to find meaningful work. It simply can not be done.

Q. Is your testimony that these people could find work if they were living in the community?

A. Yes, I believe that most mentally-retarded are capable of work. It has been demonstrated that they are capable of work and if placed in a community

setting with good community services, and community services have not always been good in the past, in fact, they have been quite bad — but given good community services that employment is very feasible.

* * *

[11-114] Q. Dr. Conley, how did you, as an economist, determine the total cost or expenditures for residential care or care in a particular facility, such as a public institution?

A. Well, as an economist, what I look for when I am attempting to estimate cost is something we call social cost, which is a fancy term for something that is really very, very simple. We want to know the full cost to Society of operating programs.

Take the case of institutional care. In Pennhurst in Fiscal 1976 the cost was about $32,000,000 or $69 per day. This actually understates the actual cost to Society of operating that facility.

The major component of living cost is the fair rental value of the building, which I would roughly estimate to be three or four dollars per day, so that the actual social cost — it was really costing the citizens of Pennsylvania to maintain the facility at Pennhurst in excess of $70 per day.

One of the fascinating — I shouldn't say fascinating, it is a very disturbing thing that has happened in institutional costs — is the enormous rise in institutional costs that has been taking place over the last 10 years. Between 1968 and 1970, when I

[11-115] was doing my work, institutional costs rose by 35 percent. Now let me give another example.

In 1970, when I was working, when I was developing some of these cost estimates, we were talking about annual cost in a residential facility of un-

der $5,000 and now at Pennhurst we are talking about average annual costs that were running about $22,000, and these increases in costs are astounding.

Q. Dr. Conley, you mentioned that *per-diem* cost at Pennhurst was the direct cost, not including the social costs, and would be $69 per day.

What was your basis for arriving at that figure?

A. That figure was arrived at by dividing the operating costs reported by Pennhurst by the resident population.

Q. Dr. Conley, in addition to your study of institutional care have you studied costs and benefits in other services to retarded persons?

A. Yes.

MR. LASKI: May I approach the witness, Your Honor?

THE COURT: Yes.

I have another question.

BY THE COURT:

Q. Doctor, I don't know, it goes back to the one I asked sometime ago. I believe you told me that according to your studies there were approximately 270,000 retarded in institutions as you defined the word.

[11-116] Were you able to break that down according to states and, if you were, what was it for Pennsylvania?

A. I could have broken it down for states, but I have to be honest. I don't have the information for Pennsylvania again —

Q. All right.

A. — at hand.

THE COURT: All right.

BY MR. LASKI:

Q. Dr. Conley, I show you PARC Exhibits Nos. 63 and 64.

Do you recognize these documents?

A. Yes, I do. They show the *per-diem* costs of operating community-living arrangements in Pennsylvania.

Q. Dr. Conley, what are these documents again?

A. They show the *per-diem* costs of operating community-living arrangements in the State of Pennsylvania, that is one document; and the other document indicates the cost of providing services to the mentally-retarded, some of the mentally-retarded in the community-living arrangement and sheltered workshops.

Q. What is the statewide average *per-diem* cost for community-living arrangements that are reflected in those documents?

A. The statewide cost is $17.64.

Q. And is there also an estimate there for cost of program services to accompany the cost of residential care?

A. For those persons in program services, which are about one third of the total community-living ar-

11-117] rangements, there is an estimate, which is $10 a day.

* * *

11-119] BY MR. LASKI:

Q. Dr. Conley, have you analyzed those figures on Exhibit 64 and reached any conclusions about them?

A. Well, I analyzed as well as I could in a short time.

I would say that one thing that does need to be made clear is that the figure of $17.64 understates the actual cost to the citizens of Pennsylvania of what community-living arrangements actually involve.

There are additional costs that have to be taken into account, one of which we have already men-

tioned, which is the cost of providing services to residents in sheltered workshops.

There are other costs that I did not see in the budget. I did not see, for example, any allocation or any consideration of the cost of special education that would be provided to some residents, which is, indeed, the type of cost that an institution like Pennhurst would incur and should have been included in these figures.

* * *

[11-121] BY MR. LASKI:

Q. Dr. Conley, you were saying that the cost of $17 per day for residential care and $10 per day for services somewhat understates the social costs.

Have you made any calculations from which you would conclude what the actual cost would be for a person living in a community-living arrangement in the five-county area?

A. Yes. It I was, you know, developing a formal estimate of social costs, I would begin with these operating costs and then look for other expenditures that were being made on behalf of the residents.

Certainly, the money spent on those residents in sheltered workshops would have to be included. Funds spent on special education would have to be included.

I did not see in the budget any allowance for medical care. That would certainly have to be taken into account.

Nor did I see any allowance for the cost of monitoring or managing the program that was incurred by the mental health-mental retardation units in the various counties.

[11-122] Now roughly I would estimate that special education programs would probably be about $4,000 per year per student, which is based on the fact that

education generally is running about $2,000 per year for students and special education is usually about twice that amount.

The provision of medical care I would estimate to be about $600 per year and case management about $500 per year.

When you translate these into *per diem* rates then you come up with the following type of very rough calculation, but in looking at social costs, if we were looking at that part of the retarded population who were attending public schools, special education classes in public schools, then one would add to the $17 that is on the exhibit another $14, which would be roughly the cost of case management, special education, and medical care, or about $31.

If you are looking at the social costs of maintaining residents in community-living arrangements who were being served in sheltered workshops, then to the $17 you would add $10, which we talked about, mentioned earlier as the average daily cost of providing services for these residents in sheltered workshops, plus another $3 for medical care and management, or about $30 a day.

If you were looking at the social cost of those residents who required minimal type of developmental services than one would take $17 and add
[11-123] about $3 to allow for the management and the medical-care components, or about $20.

Now if you take these three groups together and look for an overall average that would be comparable to this $17, which represents the social cost to the citizens of Pennsylvania, then I would roughly estimate it at about $27, which is suprisingly lower than the very high Pennhurst figure of $69, actually over $70, if you consider social costs.

And a good part of this expenditure represents what economists call investment activity of people,

that is, we are spending money on residents and facilities to help develop their vocational and social potentials for the future.

* * *

[11-124]BY MR. LASKI:

Q. Dr. Conley, I show you PARC Exhibit No. 33, entitled "Needs Assessment and Budget Projections on Deinstituionalization of Montgomery County Persons Residing at Pennhurst Center."

Do you recognize that document?

[11-125] A. Yes, I do.

Q. Have you studied that document?

A. Yes, I have.

Q. And what does that document reveal about the cost of commmunity programs for Pennhurst residents of Montgomery County?

A. Well, the document indicates that the average — no, the annual cost of moving the 133 residents from Pennhurst to the community would be a little bit less than $2,000,000 per year, $1,900,000, to be more precise.

Q. And does that document break out that cost in any way?

A. It breaks it out by the type of facilities that will be needed. For example, in dealing with the retarded, as we have already indicated, the retarded are a very heteroganeous group, that is, they are individuals, they are different from each other and have very different needs; so that the type of community-living arrangements that will be required will also be very different.

Table 2 in this document indicates the average cost for a range of five different community-living arrangements that would have to be provided for the different individuals. These costs range from $20 to about $38 per day.

Q. Do you have an opinion, after a study of this document, as to whether the cost estimates provided by Montgomery County are correct?

A. This cost estimate provided by Montgomery
[11-126] County and the description of the population to be served represents, I must say, one of the finest documents I have ever seen on planning for deinstitutionalization. They contain the type of information that Montgomery County would have to have in order to implement deinstitutionalization.

As a matter of fact, they do somewhat understate social costs for the same reasons that we talked about before, that is, they don't include the cost of providing special education, for those residents who require special education; they don't include any costs for management and they don't include any type of costs for ongoing medical needs of the resident population.

On the other hand, they do one thing that overstates costs, and that is that they include capital expenditures, which were about $100,000 in the budget. Now from a social standpoint any type of capital expenditure ought to be capitalized and depreciated over time, that is, it shouldn't charge off the full cost of any capital expenditure to a given year.

So that they were offsetting biases.

My best estimate would be as to the actual range of costs that would be relevant to the State of Pennsylvania, that is, the taxpayers would ultimately have to pay, would be somewhere in the area of $25 to $45.

BY THE COURT:

Q. Would you mind reading to yourself that foot-
[11-127] note at the bottom of Page 1 of that memorandum of February 28, the first page?

It says 130 clients for one year at Pennhurst equals what?

A. $2,888,730.

Q. Now do you know what that figure is?

A. That figure would represent an estimate of what it will cost the taxpayers of Pennsylvania if, instead of removing the residents of Pennhurst to a community-living arrangement, they must remain at Pennhurst — the cost of leaving them there, that is, the *per diem* costs, will amount to almost $3,000,000, which is far above what will be incurred if they are removed to the community.

BY MR. LASKI:

Q. Dr. Conley, would you once again give the range of daily costs for community-living arrangements that are reflected in that exhibit?

A. In Montgomery County?

[11-127] Q. In Montgomery County.

A. Well, the budget that was approved by Montgomery County gave a range of $20 to $38, which would depend on the type of facility, the highest-cost facility being a children's developmental facility which would require a good deal of individual work with the child.

Q. And is it your opinion that these estimates are

[11-128] correct and accurate estimates of the cost of care of a retarded individual in the community in Montgomery County?

A. If I was preparing a document to help choose among the alternatives of leaving individuals in Pennhurst or removing them to the community, these costs would be somewhat higher probably by a factor of three to four dollars, so that the actual range would be $24 to at most $45, which is, of course, still far below what the costs are of maintaining residents now, the retarded, at Pennhurst.

The total cost would not be much over $2,000,000.

Q. And what was the *per-capita* cost to maintain a person at Pennhurst?

A. It was $2,900,000.
Q. And that on a daily basis was what?
A. $69.

* * *

[12-19] Q. Dr. Conley, do you have an opinion as to whether it would be more costly to provide comprehensive residential and program services to those now in Pennhurst in the communities rather than to maintain them at Pennhurst?

[12-20] A. Yes, I do.
Q. Would you explain to us that opinion?
A. Yes. Based upon the documents that we have reviewed in this case, that is, the budget figures put forth on the costs of community-living arrangements from the counties themselves, based on my admittedly rough estimate of the additional costs that should be included, if one is truly to measure the cost figures that are relevant as for decision-making, that is, the social costs of community-living arrangements as opposed to allowing residents to remain at Pennhurst, allowing for the fact that cost estimates must be rough in any case, and based upon the past work I have done in mental retardation, which I guess stems back to very young days, and based upon the experience that I have gained in the area of mental retardation, there is no doubt in my mind that it is considerably less costly to provide for mentally-retarded persons in the community than in institutions.

Not only is the cost less because the services can be basically set up for the specific needs of specific residents, but there are enormous benefits in the sense that the wellbeing of the mentally-retarded and their families will be substantially improved, not just because of their ability to be employed, but because of the greater fulfillment of their lives.

* * *

Testimony of Marian Caranfa

* * *

[12-61] Q. Did you accompany George on the first day of his commitment to Pennhurst?

A. Yes, I did.

Q. Could you describe the situation as you found it when you arrived at Pennhurst?

A. Yes. Georgie was taken directly to the hospital. It was ghastly.

Here was this little seven-year-old boy and all these naked men milling around, screaming, swearing.

[12-62] He was terrified and, of course, I was heartbroken.

Q. He was admitted to the hospital ward of Pennhurst?

A. Yes, the hospital ward of Pennhurst.

They gave him a sandwich for lunch and Georgie had never been able to chew.

Q. Did anyone from Catholic Social Services accompany you?

A. A sister accompanied me.

BY THE COURT:

Q. How long had George been with you before this day?

A. All his life, seven years. He was seven years old at the time, your Honor.

MR. FERLEGER: He came to her when he was —

THE WITNESS: Five weeks old when he came to us.

THE COURT: Thank you.

BY MR. FERLEGER:

Q. Now the records indicate that in November 1969, shortly after he was admitted, he went to the habit-training ward.

A. Yes.
Q. Do you recall that ward?
A. Yes, I do.
Q. And could you describe the conditions and facilities available on that ward?
A. That was a large ward, upstairs, on top of the hospital, on the third floor.

There was a large day room with a stone floor.
[12-63] The bed quarters were over to one side. There was a great big — it looked like a play-pen, only it was six-foot sides.

I have learned later that it was a cage that they put patients in that misbehave. I never saw anyone in there.

They did have toys in there but they were never allowed out.
Q. The toys were —
A. The toys were in the cage and they weren't allowed to have them out. I never saw a toy being played with ever.
Q. But the toys were there?
A. They were there in the cage.

There was frequently urine and feces on the floor, under their fingernails, in their hair, and still is.
Q. Do you recall whether George was ever injured during the months that he was on that ward?
A. In the seven years that Georgie has been in Pennhurst there have been maybe four times that he had not been injured.

I go to see Georgie every week. Occasionally it has drifted to two weeks if I have been sick.
Q. You say four times. I am not sure —
A. Four or five times out of seven years that he has not been injured.
Q. I don't know what you mean by "times".

Do you mean times that you have visited?

[12-64] A. Times that I have visited.
Q. Restricting our conversation right now to the habit-training ward, do you recall any injuries he suffered specifically on that ward?
A. Yes. He was always bitten, scratched, black eye.
Q. Did you ever make any complaints to the staff?
A. I complained constantly.
Q. What was the result of your complaints on the habit-training ward?
A. They tried to keep me out of it.

* * *

BY MR. FERLEGER:
Q. The Pennhurst records indicate that George moved to Ward D-1 in May of 1970.
Do you recall that move?
A. Yes, I do.
Q. Could you describe the conditions on the ward as you saw them on your visit between May of 1970 and December of 1970, when he left — excuse me — and August 1971, when he left the D-3 area?
A. D-1, do you mean, to go to D-3?
[12-65] Q. Excuse me.
He was on D-1 just briefly and then he went to D-3?
A. Yes. He was in D-1 —
He was in Ward D-1. It was another large ward. There were maybe thirty-five or forty children in it.
They had French doors leading into their bed area and another set leading into where they ate. It was all almost like one big room.
There were no toys there.
He was always bitten, scratched, had black eyes, had his teeth knocked out.
Q. Now were you informed by any Pennhurst employees of any desire on their part to restrict your visits?

A. Oh, yes.
Q. And what employees informed you of that?
A. Paul Metzger and Janice Allen. They had a letter they wanted me to sign, saying that I would not interfere with the aides in the performance of their duty.

* * *

[12-66] BY MR. FERLEGER:
Q. Going back to not the latter time when Paul Metzger advised you of something, but earlier on in 1970 and '71, when George was on D-3, were you advised by any employees back then of any desire of their part to restrict your visits?
A. Yes.
Q. And who were the employees who advised you?
[12-67] A. Janice Allen.
Q. Did Norma Beard advise you?
A. Yes.

* * *

BY MR. FERLEGER:
Q. And why did they tell you that they desired you to limit your visits?
A. Because I complained and they said that that disturbed them.
Q. Disturbed who?
A. Disturbed everybody.
Q. The residents or the employees?
A. The employees.

* * *

Q. Were there ever any injuries that George received that came to the attention of Dr. Youngberg?
A. Oh, I tried, but I never could get in to see him.
Q. What would happen?

A. One day I went to see Georgie and he had a bite as big as a grapefruit on the inside of his knee and I waltzed him right over to the office.

Of course, I didn't get to see him.

On many occasions I called him and tried to get
[12-71] to see him.

Q. And what was the response of Dr. Youngberg to those requests?

A. I never saw him and I could never get past his secretary.

Q. Did Dr. Smilovitz or any other officials ever become personally aware of any injuries to George?

A. Yes. On that occasion of the large bite on the knee, Dr. Smilovitz came out and spoke to me and he sent for Norma Beard and we talked together.

I wanted Georgie placed in a ward where he wouldn't be hurt in this way. I wanted him removed from the biters and the stronger children; and they said there wasn't any place else they could put him and I would just have to be satisfied to leave him where he was.

Q. Do you know if any doctors at that point saw that particular injury?

A. Dr. Robles was in the office when I went to dress George and saw the bite and I became excited and she said, "I don't blame the parent, this is a vicious bite."

* * *

[12-78] Q. Did you ever see any abuses of residents by aides on D-1?

A. Yes.

Q. And will you describe that, please?

* * *

Q. Do you recall about when that was? '72, '73, '74?

A. Around '72.

Q. Will you describe that?
A. Yes. An aide — it was around mealtime. I went in the dining room to help feed Georgie.

As we went into the dining room a patient was getting a drink from the soda fountain. The aide struck the patient and swore at her.

We all went into the dining room. While I was feeding Georgie the aide was slapping several different patients about the arms and shoulders and then she took one child by the back of the neck and held open the swinging door with one hand and threw the child through and he landed on all fours in the other room.

[12-79]

At that time I went downstairs and told Norma Beard there is an aide up there mistreating those children.

Q. Do you know how far the child was thrown?
A. Five or six feet, I'd say.
Q. The child started out in the air, off the ground?
A. Yes.

* * *

[12-80] Q. The records indicate that George was on Ward D-1 from November of 1971 to May of 1972.

Do you recall any incident on that ward that stands out in your mind?

* * *

The Witness: Well, what do you mean, incidents involving Georgie or other patients?

BY MR. FERLEGER:

Q. Either.
A. There was one time when there was a baby lying on the floor and the flies were in her mouth and nose and I picked them out and asked the girl who worked at Pennhurst, Dorothy, in charge of the ward, to do something about it.

And she said, "Well, what do you think I can do?"

[12-81] And I came downstairs and complained to Norma Beard and I said they should have the baby in a crib with mosquito netting over the crib.

It was summer and there were a lot of flies drawn by all the urine and feces all over the place.

And when I came the next week the baby was in an inner crib and they had a netting, it looked like a big fishing net. It had holes in it this big, and a dive-bomber could have went through the holes and got on the baby's face.

* * *

[12-82] Q. Were residents showered in the normal fashion on the ward C-1?

A. On the T building they had a big room with a broken cement floor. I got there very early one day to take Georgie out for the day and they were being squirted down with a big hose.

There was a crippled girl about eighteen naked in the wheelchair, in the doorway, trying to dry them as they passsed out of the room.

[12-83] Of course, the children were all screaming hysterically at this procedure.

Q. Screaming with delight or happiness?

A. Delight? Screaming with fear.

* * *

THE WITNESS: I know my baby was scared to death. Let's put it that way.

BY MR. FERLEGER

Q. Do you recall Christmas 1976?

A. Yes.

Q. Did you pick up George at that point and come home?

A. Yes.

Q. Could you describe his dress at that time?
A. Yes. I had bought Georgie a coat in the beginning of the year and it was torn, he wasn't able to wear it.

They gave him a coat that was an absolute rag. The sleeves were all frayed, the zipper was torn out of the front. They closed it with a big pin.

We stopped at the first store and bought Georgie another jacket, and when I came home I called Dr. Youngberg.

[12-84] At this time I did get him and I told him that my son should be dressed in better fashion and he agreed with me.

But subsequently Georgie never did get another coat.

Q. This was the coat they gave him to go home for the weekend?
A. Yes.
Q. To the community?
A. Yes.
Q. Was George Sorotos ever physically restrained in any way?
A. Yes. When he was in D-1 I used to go up and see him and he would be —

MR. WATKINS: Objection as to the time, your Honor.

BY MR. FERLEGER:

Q. That would have been, as I look at the records, from June of 1972 to May of 1973?
A. As nearly as I can remember.

He would be tied to the bench. Often he would be walking around the floor on all fours pulling the bench with him.

Q. I don't understand.
A. Well, he would try to get up and he'd fall over. The bench was tied to his back, so he would just drag it around.

[12-85] Q. Did you ever see any physical marks or injuries from that?
A. He got many bruises from the tightness of the band until one day I said I never, never wanted to see that on him again; and then I didn't.
Q. Mrs. Caranfa, I show you Defendants' response to Interrogatory 19 of the plaintiffs regarding George Sorotos.

The question was whether physical restraints or seclusion had ever been used on the plaintiff, and I note only one incident that's noted, of October 31, 1974 — seclusion for pulling hair and punching boys and aides; but nothing about restraints.

Is it your testimony that this is not a reflection of the number of times he was under restraint?
A. That's not true. I became alarmed at the restraints after Dennis died.
Q. Dennis?
A. A patient. He was restrained and strangled to death.

* * *

[12-87] Q. Has George ever been burned at Pennhurst?
A. Yes.
Q. Can you describe what you know about that?
A. Only what I see, and they look like cigarette burns on his chest.
Q. And how recently have those burns been observed?
A. A couple of months.

* * *

Testimony of Doris Taylor

[13-11]BY MR. FERLEGER:

Q. Mrs. Taylor where do you live?

A. 51 Trellis Road, Levittown, Pennsylvania.

Q. You are the mother of two of the plaintiffs in this case, Lawrence Taylor and Kenneth Taylor?

A. I am.

Q. When was Larry Taylor born?

A. February 14, 1956.

[13-12] Q. And how did you come to know that he was retarded?

A. Quite a while after he was born. He didn't develop normally. At the end of a year he couldn't even hold a rattle, he couldn't roll over.

He just laid on his bed on his back, with his head on the side.

Actually, it wasn t a doctor that told me that he was retarded.

Q. What did the doctor tell you? What did you learn from the doctor when you brought symptoms to the doctor's attention?

A. Well, they kept treating him like a sick child. I mean they never mentioned anything about development or anything else.

He was very tiny when he was born. He only weighed three pounds three ounces.

When he was only a month old they thought he had hydrocephalus and was sent down to Children's Hospital.

Q. When did you learn that he was retarded?

A. I tried to enroll him in a pre-school program and he didn't qualify.

Q. How old was he?

A. Oh, I am really not sure. He must have been about three.

He wasn't toilet-trained; couldn't feed himself.

At that time he could sit, but in a sitting position on the floor he couldn't move. I mean he just sat and to qualify for any pre-school program he
[13-13] would have to be able to take care of himself.

So the woman that was taking the applications actually is the one that said that he was retarded and to her knowledge there wasn't anything in the community to put him into.

* * *

BY MR. FERLEGER:

Q. Did you get any assistance at all from any community programs with Larry Taylor?

A. The only thing I got was through Easter Seals. They had given me a few exercises to strengthen his legs and at one point they suggested a standing box to teach him to stand.

Q. And how long did those exercises continue?

A. They continued until Ken was born.

Q. And when was that?

A. He was born November 13, 1957.

Q. And how does he come to be retarded?

A. When he was three months old he contracted a virus. He was very, very ill.

* * *

Q. How did you come to know that he would be retarded?

A. Well, he seemed to be perfectly normal before he went into the hospital. When he came out he couldn't do anything. He couldn't hold his head up.

He was pretty much in the same condition as Larry at that point.

Q. And what help did you get in the community in caring for him?

A. Nothing.

Q. Did you ever contact any county officials?

[13-15] A. Yes, I did. There was a woman that came to my house quite frequently and they suggested I put both children on the waiting list for an institution. I can't remember the name, but it was strictly for crib cases.

Q. And did you do that?

A. I told her I couldn't do that. I said that I had worked so hard with both kids.

I did get them to the point, both of them, where they could sit and they could get around in baby-walkers; and I said I just couldn't do that.

What I wanted for them was some place to give them physical therapy, to teach them the things that they didn't know.

Q. How did you come to consider admitting them to Pennhurst?

A. I finally got to the point of desperation. Larry, he never slept at night, he never slept during the day. He would cry continually.

The only way I got any sleep was if my mother would come in once in a while and relieve me.

The two children were in the same room. If one started, if Larry started he got Ken up and I had to stay up at night because my husband had to work. He needed his sleep.

And it was a strain during the day and one thing led to another and unless you have been
[13-16] through this you never know how bad it is.

I really thought I was loosing my mind, so finally, Miss Harr, that was the lady's name, she suggested —

* * *

BY MR. FERLEGER:

Q. The woman you mentioned, were did she work?

A. She worked for the County, but I am not just sure what her position was.

Q. And what happened with regard to committing the children to Pennhurst?

A. She did all the arranging, and like I say, I was in such a mental state that in January of 1961 she took Larry and put him in a private facility, hoping, she said, that the application for Pennhurst would be through shortly, but she realized that he was the worse of the two.

And I just couldn't go on any more and, as it turned out, in February of that year, Pennhurst did
[13-17] contact me and they were accepted.

* * *

[13-24] Q. Were you ever asked for permission by anyone on the Pennhurst staff for the drugging of your children?

A. Never.

Q. Were you ever given any information about the effects and side effects of drugs they were receiving?

A. Never.

Q. Did you ever make any inquiries of the Pennhurst staff regarding the medication of your children?

A. I did for Larry because he got to the point where he was so lethargic that he could barely walk. After 1971, when the children went off the grounds to school, he would fall asleep in school.

So I really don't think he got anything out of that and I did ask, you know, what he was on.

I found out that he was on Dilantin for seizures. My child only had one seizure in his life and that's
[13-25] when he was a baby.

Q. Were you ever told that Larry was an epileptic by Pennhurst?

A. No.

Q. Were you ever given any indication at all that they considered him an epileptic?

A. No. I was not.

Q. When you took him home on weekends did you get seizure medicine, like Dilantin to take home for the weekend?
A. I didn't bring him home because I had brought them home on a couple of times and they said that they felt that they regressed at home.

So actually we went there to visit rather than bring them home.
Q. Did you ever discuss the drugging of Larry with Dr. Youngberg?
A. Yes, I did once. We were at a parents-staff meeting.
Q. Do you recall about how long ago that was?
A. No, not really.

I can't give you an exact date, but Larry, as I say, had reached the point where he couldn't get around and I had carried him over to Dr. Youngberg and I told him to look at my child, he was almost a vegetable.
Q. And did you discuss with him whether this was the result of Larry being on medication.?
A. I told him I felt it was.
[13-26] Q. And what did Dr. Youngberg reply?
A. He shook his head and said "Shouldn't be, shouldn't be."
Q. Did you ever hear back from him regarding that complaint?
A. No, I didn't; but I did finally, after all those years, get to talk to Larry's doctor.
Q. And what was the occasion for that happening?
A. It was at one of the very few meetings that I attended and I explained to her to my knowledge; you know, he had never had a seizure, I couldn't understand why he was on this medication.

This was not the doctor that prescribed the medication, by the way.
Q. Okay.

Now did you make these complaints about the medication to the entire team meeting?
A. I did.
Q. And your testimony was that there was a doctor there at the meeting?
A. Yes, there was.
Q. And who was that?
A. Dr. Robles.
Q. Enid Robles?
A. That't right.
Q. And what did she reply?
A. She listened to me. Finally somebody listened to me and she said she would —

* * *

[13-27] THE WITNESS: She said she would check into the record, which she did; and she did get back to me and she checked way back; you know, she said, when he came to the institution, and she could find only one episode of a seizure and she agreed to remove him from the Dilantin.

BY MR. FERLEGER:
Q. And do you know whether that happened?
A. That happened, but then I didn't find out until later he was put on Mellaril.
Q. And were there any problems with the administration of Mellaril to Larry Taylor?
A. There again he got very lethargic.

* * *

[13-28] BY MR. FERLEGER:
Q. Did you make any complaints regarding the effect of drugs on your son?
A. Yes, I did.
Q. To whom?
A. I spoke with Nancy Everson and I spoke to another social worker later, Paul Metzger, about it.

There was no reason given to me why he was on Mellaril.
Q. Did they agree that the Mellaril was causing the lethargy?

A. Yes.
Q. And did anything come of your complaints regarding the Mellaril?
A. No.
Q. Where is Larry Taylor now?
A. At Woodhaven Center.
Q. Does he receive medication there?
A. No, he does not.
Q. Does Kenneth receive any medication now?
A. Kenny is still on Mellaril. I am trying to get him off that.
Q. And where is Kenny now?
A. Woodhaven Center.

* * *

[13-29] Q. Do you recall seeing in my office a list of accident and injuries that the children received?
A. I did.
Q. I notice that many of those accidents are characterized as minor by Pennhurst.

Would you agree with that characterization?
A. I certainly would not.
Q. Why not?
A. I suppose there is — well, I should not say that.

The accidents that I witnessed with both of my children, many of them were quite serious, I felt. Many of them required a number of stitches in the head area, in the face area.

They were battered and bruised, bitten, scratched.
Q. Were either of your children ever hospitalized within the hospital at Pennhurst for any of these injuries?
A. Larry was.
Q. Will you describe the length and nature of the hospitalization?

[13-30] A. He was beaten about the head and face so badly he was unrecognizable. You couldn't see eyes, nose, and mouth. I mean he was totally beyond recognition.

He spent two weeks in the hospital.

Q. If a network of community services were available for the care of residents at Pennhurst, would you agree that Pennhurst should be closed?

A. (There was no response.)

Q. Can you can explain your answer, if you wish.

A. Yes. There is nothing more that I would like as a parent than to have my children close to home.

I do realize that they require a lot of structure, a lot of reinforcement. Such a facility is not available at this time.

Q. Did you ever have any contacts with your base service unit regarding the stay of your children at Pennhurst?

A. To tell you the truth, I wasn't aware of a base service unit until right before my children were transferred from Pennhurst. That was my first contact.

Q. The base service unit had never contacted you about your children?

A. No, they had not. Even then they didn't. I called them.

Q. And that's how your children got out of Pennhurst?

A. Not through the base — well, I suppose — I can't give you an honest answer on that.

[13-31] I suppose Pennhurst worked along with them but without my knowledge.

* * *

[13-39] Q. Have you been contacted by the base service unit since that initial contact that you had when they were transferred?

A. Yes, I have been.
Q. Are you having regular contacts with them now?
A. No, indeed, I do not.
Q. How many times have you had contact with them?
A. Initially, quite frequently; but then I got a new social worker and I haven't really talked to them at all to any degree.
Q. Are you discussing or have you discussed community placement?
A. I tried to.
Q. Why do you say tried to?
A. Because I called him and wanted to know if there was anything in the community.

He acted as if he didn't even care to discuss it with me. He has not turned up at my children's program-planning.

[13-40] Q. This is at Woodhaven?
A. Right.
Q. Do you recall his name?
A. I only know his first name.
Q. What's that?
A. Richard.
Q. And he is with the Bucks County —
A. He is in Penndel.
Q. I am sorry?
A. In Penndel.
Q. Is he a County employee, as far as you know?
A. As far as I know.

* * *

Testimony of Elizabeth Bowman

[13-67] BY MR. FERLEGER:

Q. Mrs. Bowman, how old are you?

A. Fifty-six years of age.

Q. And where do you live?

A. 146 Mildred Avenue, Roslyn, Pennsylvania.

Q. In what county is that?

A. That is in Montgomery County.

Q. And you are the mother of the plaintiff, Nancy Beth Bowman?

A. Yes, I am.

Q. When was she born?

A. December 12, 1950.

Q. And were her first couple of years of life normal?

A. Yes, they were.

Q. Then what happened?

A. At the age of nineteen months Nany Beth developed or contracted encephalitis, which left her severely brain-damaged.

Q. And is that when you learned that she was retarded?

A. Yes, I did.

Q. What sort of care did she receive for the first
[13-68] four or five years of her life?

A. Of course, we went from doctor to doctor for tests and enrolled her in a private day school in Chestnut Hill that had programming, speech therapy. She received speech therapy and they taught her to read and to print and she was there for about two and a half years and the school had to close its doors due to a financial problem.

Q. And then where did she go?

A. Nancy Beth didn't go any place after that. We contacted our school district to see if they ad a program for Nancy Beth and at that time there wasn't anything available.

Q. How old was she then?
A. She was six then.

When she was seven years of age the Abington School District set up a day-care program for mentally-retarded youngsters and Nancy Beth was enrolled in that program for about a year and a half.

During her first six months Nancy went to a full day program. However, due to her hyperactivity, — Nancy Beth is extremely hyperactive — they —
Q. What kind of hyperactivity did she exhibit then?
A. She was in constant motion. She could not sit still for periods of time.
Q. Did she hit anybody, bite anyone, hurt anyone?
A. No she was not abusive.
[13-69] Q. What precipitated your consideration of committing her to Pennhurst?
A. We did not have any other programs in the community for her and she became difficult to handle on a twenty-four-hour basis.
Q. Did you get any help from the Montgomery County Health and Welfare Department?
A. We contacted Montgomery County Health and Welfare Institutional District to see if there were any places available for Nancy Beth and they at that time informed us that there were state institutions for her.

However, our doctor, in the early years of Nany Beth's training, advised against placing Nany Beth in an institution. That's why we were looking for outside help so that she would not have to go to an institution.
Q. Did you visit Pennhurst or any other State institution prior to admitting Nancy Bowman there?
A. Yes, we did. We went to many private institutions.

However, the tuition fees were beyond our means and we were out to Elwyn and Pennhurst.

We did tour Pennhurst prior to Nancy Beth's admission.

Q. What did you see on that tour of Pennhurst?

A. Of course, we were shown the high-functioning-level wards at Pennhurst, where children were participating in the school program. We were shown

[13-70] the sewing classes that the young women were sewing, and their cooking classes, which they said residents were able, with training, to get into these programs.

Q. What was Nancy Beth's physical condition at the time she was admitted to Pennhurst?

A. She was in perfect physical condition.

Q. Did she have any scars that you know of?

A. Yes. She did have one scar on her lower left arm. We had a storm door installed in our home and we were not aware that it was not safety glass in this storm door and due to an accident Nancy did not know the door was locked and she pushed on the door and went through the bottom of the storm door.

Q. Did she have any other scars?

A. No. she did not.

* * *

BY MR. FERLEGER:

Q. At the time that she was admitted to Pennhurst

[13-71] did she have a habit of biting other residents?

A. No, she did not.

Q. Do you recall, if you know, about how long after her admission she developed that habit?

A. I believe it was in her second year at Pennhurst when she developed maladaptive behavior or biting.

Q. In those early years of her commitment at Pennhurst did you visit Nancy Bowman on the wards?

A. No. Parents were not allowed to visit the patient on the ward.

However, I did request permission. I was interested to find out what type of living arrangements were made for her, so I did have permission to have a visit to the ward.

Q. And that would have been in the early 1960s?

A. That was in the early 1960s.

Q. Could you briefly describe what you saw?

MR. GOLDBERG: Will you note my objection on the time period, your Honor.

THE COURT: The objection is noted.

You may proceed.

THE WITNESS: It was a large room with sixty-five residents and the majority of the times there were two child-care aides in attendance.

BY MR. FERLEGER:

Q. And what else did you see on the wards?

[13-72] A. Well, then — the first ward she was on, they were school-age children and we were hopeful that Nancy Beth would enter the school program that Pennhurst had for children.

When we first visited the ward the majority of the girls were in session in school.

Q. Did you ever receive any requests from Pennhurst staff or officials during the 1960s for medication of Nancy Bowman?

* * *

THE WITNESS: We never received, we never were requested to give consent for mediction to Nancy Beth.

BY MR. FERLEGER:

Q. Was that during the 1960s or during the entire time?

A. That was in the 1960s, in her early years at Pennhurst.

Q. Do you know whether she was injured at all at Pennhurst during the 1960s?

* * *

THE WITNESS: Yes. We would visit Nancy Beth quite frequently and when she would be brought down to us in the visiting room we would see that she was bruised constantly, marked, black eyes, slight things, sutures, and very lethargic.

BY MR. FERLEGER:

Q. During the early years at Pennhurst did she re-
[13-73] ceive any injuries to her teeth?

A. I'd say the first year Nancy was at Pennhurst, on a visiting day we were informed by a nurse, Miss Landis, that Nancy had pulled one of her teeth herself, pulled her teeth out herself.

In 1963 we had visited Nancy Beth and she was without one tooth and one tooth had been fractured, which they had informed me that —

* * *

BY MR. FERLEGER:

Q. Could you tell us who informed you, if you know?

A. The nurse in charge of Nancy Beth.

Q. And who was that?

A. Mrs. Landis, I believe.

Q. L-a-n-d-i-s?

A. L-a-n-d-i-s.

Q. Did any doctor speak to you also about the dental problem at that time?

A. No. We did go to the dental — the doctor in charge of the dental clinic at that time and we wanted Nancy's teeth to be replaced.

Q. What did Nurse Landis and the doctor tell you?

A. Dr. San Luis and Miss Landis, the nurse, asked us not to have Nancy Beth's teeth replaced because they felt it would be detrimental to her in the event that she was knocked down and pushed, that there
[13-74] was a possibility that she would swallow these teeth.

Q. If they were replaced?

A. If they were replaced.
Q. Were her teeth replaced or capped at all during those years?
A. Yes, they were.
Q. By whom?
A. By our family dentist.

* * *

Q. Do you know whether Pennhurst had any policy regarding dental work at that time?
A. At that time we were informed by the doctor in charge of the Dentistry Department that they did not do dental restructuring.
Q. Did there come a time when you requested a transfer of Nancy Bowman out of Pennhurst?
A. Two months — I believe it was June 1961. We were very unhappy with all our visits to Nancy Beth, that being she was constantly bruised and marked up. Mr. Bowman and I felt that Pennhurst was not a place for Nancy Beth.
Q. What did you do?
A. And we went to the Social Service Department
[13-75] and requested that Nancy Beth be dismissed from Pennhurst.
Q. And do you recall whom you spoke to and what her response was?
A. I believe I received a letter from Pennhurst asking Mr. Bowman and I to come out to Pennhurst to discuss this problem.

At this meeting —

Q. Do you recall who was there?
A. Dr. San Luis, I believe, and I believe at that time it was Mrs. Flora Gross, the Director of Social Services.
Q. Was the superintendent there?
A. The superintendent was not at this meeting. However, I had spoken to Dr. Potkanski after this meeting.

Q. Yes?
A. And they informed us that once we removed a resident from a State institution we would never be able to get her into another institution, so we reconsidered doing this.
Q. Do you recall any incident you became aware of about Easter 1970?

MR. GOLDBERG: I object.

THE COURT: The objection is noted.

You may answer.

THE WITNESS: Good Friday of 1970 we went to pick Nancy Beth up to take her home for the Easter vacation.

Nancy Beth's teeth were not in her mouth and they told — Nancy Beth told us that someone
[13-76] smacked her in the mouth and knocked her teeth out.

BY MR. FERLEGER:
Q. You say her teeth were not in her mouth.

Will you explain exactly what you mean?
A. We had Nancy Beth's teeth restored. We had a permanent bridge made in her mouth with caps.
Q. How many of her teeth were involved, do you know?
A. I believe there were four at that time.
Q. It was those teeth that were gone?
A. The complete permanent bridge, yes.
Q. Do you recall making any complaints to anyone at Pennhurst regarding the loss of those teeth?
A. Yes. We did talk to — they did call Dr. Soroka to the phone to find out what happened to Nancy Beth's teeth.
Q. And that would have been —
A. That was the same day that we picked Nancy Beth up.

He was not on duty that day but they did get him from his home to come out to speak with us.

Then we also went to Administration and talked with Dr. Hirst and told him of the incident.

Q. Did Pennhurst replace the bridgework?

A. Mr. Bowman insisted that Pennhurst take care of this problem at this time because this would have been about the fifth or sixth time that we had these teeth replaced.

Q. Do you recall whether Nancy Bowman was
[13-77] placed in seclusion at any time during the 1960s?

MR. GOLDBERG: Note my objection, your Honor.

THE COURT: The objection is noted.

You may answer.

THE WITNESS: Yes, Nancy Beth was in seclusion in the sixties.

BY MR. FERLEGER:

Q. Do you recall the longest period of time that she was kept in seclusion?

A. For days, I would say.

Q. For days at a time?

A. Days at a time, yes.

Q. Do you know why?

MR. GOLDBERG: Objection.

BY THE COURT:

Q. Did anyone at Pennhurst ever explain to you why or tell you why?

A. Yes, because she had developed many maladaptive behaviors.

BY MR. FERLEGER:

Q. Like what?

A. Biting, pushing, —

Q. And did Pennhurst staff ask you to take any action regarding those behaviors?

A. Not in the sixties, no.

Q. Now in about 1970 did Nancy move to Ward Q-2?

[13-78] A. Yes. The social worker at that time asked Mr. Bowman and myself if we could consider placing Nancy Beth in a modified — a behavior-modification program.

Q. And who is it that asked you to place her in the program?

A. Alexander Mansfield, social worker.

Q. And did he explain the nature of that program?

A. Yes.

Q. And who explained it?

A. The unit director at the time was Bruce Yoppi.

Q. Y-o-p-p-i?

A. Y-o-p-p-i, and the social worker was Joseph Scotti, S-c-o-t-t-i.

Q. And what did they tell you about the program?

A. They explained behavior modification to us that for bad behavior Nancy Beth would receive negative reinforcements and with good behavior she would receive positive reinforcers.

Q. And what were the negative reinforcers to be?

A. The negative reinforcers were to be placed in muffs and restraint and seclusion.

Q. And what did they tell you were the expected results from that program?

A. They were very optimistic and felt that Nancy Beth could be helped.

Q. And did they tell you any possible negative effects of the program, or risks?

A. No, they did not.

[13-79] Q. That was in 1970?

A. That was in 1970.

Q. Have you any knowledge about whether the behaviors that program was aimed at increased or decreased since that program was initiated?

A. I am sorry, I didn't understand.

Q. Do you know whether the abusive behavior at which that program was directed has increased, de-

creased, or remained the same since the program started?
A. Well, Nancy's behavior is the same.
Q. Now does she bite or is she abusive at home?
A. No, she is not abusive with the family.
Q. How often do you have her at home?
A. We visit Nancy Beth at least every two weeks and we have her home for vacation once every six weeks, if possible.
Q. How long?
A. For a period of four days to a week; and we also take her on vacations.
Q. And on those vacations and at home does she bite anyone?
A. No, she does not.
Q. Does she scratch or abuse herself?
A. Nancy is self-abusive, yes. When she becomes frustrated, yes, she will hit her head and hit her arms.
Q. When she becomes frustrated?
A. When she becomes frustrated.
[13-80] Q. When would that be?
A. If she is not kept busy, if she is — we can never give Nancy Beth a negative answer. If we give her a negative answer it frustrates her.
Q. Although she abuses herself, does she abuse anyone else on those visits?
A. No, she does not.
Q. From 1970 to let's say 1974, when the lawsuit was filed, on Ward Q-2, will you describe how she was dressed?
A. Nancy Beth was usually dressed in State clothing, even though there is availability of clothing which is supplied by her family.
Q. When you say her family do you mean yourself?
A. Right.
She has never — she never has shoes or socks on.

Q. Did you and your husband bring clothes to Pennhurst for her use?
A. Yes, we do.
Q. Does she wear those clothes at Pennhurst?
A. They are visiting clothes. They are used as visiting clothes.
Q. What is that?
A. When you go pick up your child, that when you take her out she will have proper clothes to wear.
Q. But not locked up in the ward?
[13-81] A. But not locked up in the ward.

Things have improved, though. I do see the residents in normal-looking clothing.
Q. Would that be since 1974?
A. Since 1974.
Q. Do you recall any incidents of abuse by staff at Pennhurst of your daughter?
A. Yes, I do.
Q. I'd like to show the Defendants' answers to Plaintiffs' interrogatories regarding Nancy Bowman.

Question Number 23 was has plaintiff ever been struck by a staff member? If yes, what action was taken against such staff member? Give details and date.

Would you read this short paragraph called Incident Number 1.

* * *

THE WITNESS: A report was made to the Unit 8 director that an employee had witnessed resident Nancy Bowman being slapped on the face by another staff member. The witness was questioned and confirmed that the slapping incident had occurred.

The staff member who allegedly had struck Nancy was questioned and admitted that he had struck her. Employee resigned effective 10-6-71 in lieu of suspension pending removal.

BY MR. FERLEGER:

Q. Is that the end of that incident?

A. Yes.

Q. Were you informed by Pennhurst of that slapping of your child by an employee?

A. No, I was not.

Q. When did you first learn of that incident?

A. When I read the report in your office.

Q. How long ago?

A. A month ago, in April.

Q. What is the second incident?

A. A staff member was observed by another employee slapping Nancy Bowman on the back and upper arms after she had bitten another resident. The incident was reported to the Unit director on the same day, 3-8-73.

The unit director interviewed the staff member involved, who admitted slapping Miss Bowman.

[13-83] Staff member was suspended immediately, 3-8-73, and upon completion of an investigation of the incident the employee was removed on March 21, 1973.

Q. When did Pennhurst inform you of that abuse of your child?

A. I was never informed of that abuse.

Q. When did you first learn it?

A. When I saw the report in your office in April.

Q. Is there a third incident there?

A. Yes.

Q. Would you read that?

A. Nancy Bowman was found with numerous large bruises on both buttocks on 12-26-73. The marks were of a suspicious nature and origin, so all staff members involved with Miss Bowman were questioned and the State Police were requested by Pennhurst administration to investigate the injuries.

After extensive inquiries and multiple interviews a staff member confessed to State Police investigators to having struck Miss Bowman with a shackle belt on the evening of 12-24-73 in an attempt to stop Miss Bowman from beating another resident.

State Police informed Pennhurst State School authorities on January 28, 1974 of the development. The employee was interviewed by the unit director and assistant director of resident life.

She repeated her confession and was sus-
[13-84] pended immediately on January 28, 1974. Upon completion of investigation employee was removed for patient abuse on February 4, 1974.

The removal action was, however, refused by the local branch of AFSCME. Removal was upheld through the third step of the appeal procedure.

* * *

[13-86] Q. Did you ever make any complaints regarding medication of your daughter to any Pennhurst employees?

A. Yes.

Q. Will you describe those complaints and what caused you to make them?

A. Well, all through Nancy's stay at Pennhurst we did complain about the medication that Nancy Beth was on because we had found in her years home with us that medication agitated Nancy Beth to the point where she was more active.

Q. Did you tell any Pennhurst employees that she was better off without the medication?

A. Yes, I did.

Q. And whom did you tell that to?

A. All the doctors that were on Nancy Beth's unit.

Q. Do you remember the names of any of the doctors or non-doctors that you told that to?

A. We complained to Dr. Leov, the nursing staff, Miss Landis, many other nurses that I cannot recall their names because this is going back years now, Dr. Fanaway.
Q. Any unit director or non-doctors?
A. Yes. I believe we discussed it with Mr. Pirmann.
Q. Greg Pirmann?
A. Greg Pirmann, now Unit Director of Unit 8.
Q. He is sitting here in court?
[13-87] A. Yes, he is; and also with Nancy Beth's social worker, who is John Schaeffer.
Q. Did Dr. San Luis or Greg Pirmann indicate whether they would take action on your complaint?
A. Yes, they did.
Q. What did they tell you?
A. Nancy Beth was removed from many of the medications that she was on.
Q. Did you ever receive any complaints or remarks from Pennhurst officials regarding the use of the drug Prolixin on Nancy Bowman?
A. Yes. Mr. Bowman and I were asked permission to place Nancy Beth on Prolixin, which was to relieve some of her hyperactivity.
Q. Do you recall about how long ago that was?
A. I would say that was approximately four years ago.
Q. And do you recall who asked you for permission?
A. Dr. Konia.
Q. Harold Konia?
A. Who was a consulting psychiatrist, and Mr. Pirmann, Dr. San Luis, I believe it was at that time.
Q. What did they tell you about the side effects or risks of that drug?
A. We were informed that there were not side effects to Prolixin.
Q. And each of those people — Greg Pirmann, Dr.
[13-88] San Luis, Dr. Konia, informed you that there were no side effects?

A. I am sure that Mr. Pirmann would not know because he is not in the medical profession.

However, Dr. Konia and Dr. San Luis felt that there would not be any side effects or adverse reactions.

MR. WATKINS: Your Honor, did the witness say they felt that or they said that?

THE WITNESS: They said that there would not be any adverse reaction to Prolixin.

* * *

BY MR. FERLEGER:

Q. Since the doctors informed you that there would be no side effects or risks from the medication, at that point did you agree to the medication?

A. Yes, we did. We gave our consent to the medication to be used.

[13-89] Q. Since then have any physical problems developed in Nancy?

* * *

THE WITNESS: I would say it was four years ago we were asked permission to give Prolixin and approximately two — two and a half years ago Nancy Beth developed tremors and shakes in the right side of her body.

BY MR. FERLEGER:

Q. Will you describe exactly what you mean by tremors and shakes?

A. Arm-shaking and right-leg-shaking, right arm and right leg shaking.

* * *

[13-90]BY MR. FERLEGER:

Q. Did Nancy Bowman's right to have visitors ever become restricted at Pennhurst at all?

A. Back in the sixties, I really don't know exactly what year, it was about '66, I believe, that as a punishment for Nancy Beth because of her behavior problems they requested that we — they refused to allow us to visit Nancy Beth.

Q. Do you know whether Nancy Bowman was involved in any speech-therapy programs at Pennhurst?

A. She is not involved in any speech-therapy program.

Q. Were you aware of any recommendation of April 29, 1975 that she be enrolled in a trial speech-therapy program?

A. The last I spoke with the speech therapist, he was not working with Nancy Beth. That was just the latter part of '76.

Q. Are you aware of any programs at Pennhurst which were successful in reducing or eliminating Nancy's abusive behavior toward others?

[13-91] A. Nancy is in programs in Unit 8. She is on a behavior-deceleration program. She is in a self-skill-help program. She is involved in recreation activities.

Q. Have they been successful in reducing her abusiveness?

A. Not in reducing her abusiveness.

Q. Were you ever told by Pennhurst that their February 17, 1977 annual program review recommended that she be placed in a smaller institution and community alternatives because of the reduction in stimuli and conflicting sessions?

A. Yes, I was.

Q. Do you know what action Pennhurst has taken to get her into that sort of alternative program?

A. I don't believe there is any alternative program.

* * *

[13-92] Q. Do you know whether Nancy received in 1975 any occupational therapy?

A. 1975? I believe maybe she did.

Q. The occupational-therapy evaluation report dated April 1st and May 16th indicates that these individual treatments were canceled due to lack of staff.

* * *

Testimony of Alexander Hersh

[13-115] ALEXANDER HERSH, having been duly sworn, was examined and testified as follows:

MR. GILHOOL: Your Honor, I have handed up to the *curricula vitae* of Drs. Hersh and Walker and Thurman, which are PARC Exhibits 12, 13, and 14, respectively.

Dr. Hersh will testify about the conduct and design of the study at Pennhurst; Dr. Walker will testify about the conclusions and recommendations from their work, and Kenneth Thurman will testify to the findings.

THE COURT: All right.

MR. WATKINS: Your Honor, if I may, you will note outstanding objection to the testimony and the conclusions formed as a result of our retaining them for the defense.

We have no objection to them testifying as to what they saw factually.

We do object to their testifying to conclusions and it is my understanding — and I don't want to make a repeated objection to those types of questions.

[13-116] THE COURT: As I understand it, this is the question I already ruled upon.

MR. WATKINS: That's correct, your Honor.

THE COURT: All right.

DIRECT EXAMINATION

BY MR. GILHOOL:

Q. Dr. Hersh, have you had occasion recently to conduct an index study of all of the facets of the operation of Pennhurst State School and Hospital?

A. Yes.

Q. Will you describe, please, the design of the study and your conduct of it?

A. Okay.

The study was requested by Wilbur Hobbs.

Q. Deputy Secretary of Public Welfare for the Southeast Division?

A. Yes, Southeast Division for the Department of Public Welfare, in December of 1976.

Mr. Hobbs and Dr. Rice, one of his associates, met with myself, Dr. Walker, and Dr. Thurman around the 22nd of December. We also had conversations at that time with Mr. Watkins — I think he was calling from Harrisburg — so that it was a multi-person conference in which they laid out for us the kind of study they asked us to do.

Essentially, what they wanted us to do was a
[13-117] comprehensive, objective evaluation of Pennhurst. They specifically asked us not to do what they called a whitewash. They wanted detailed information; they hoped for a balanced comprehensive product.

At that time there was considerable discussion about the nature of the project. We all considered ourselves to be professional people and, therefore, we wanted to make it very clear that we would not conduct a study which had any conditions about the data which we would obtain. In other words, we saw this as a professional study in which we would design the study, obtain the data, and present them with the results of the study.

I emphasize that because there was considerable discussion about whether or not we would be getting information "for the defense" and we felt that if that was all we were doing — was fact-finding for the defense — that would not be in the nature of a professional report.

So that point having been clarified, we proceeded with the study.

Q. If I may, Dr. Hersh, for a moment, Deputy Secretary Hobbs was clear that there were no such conditions upon your study?

A. Yes.
Q. And were the lawyers whom you mentioned and the Attorney similarly clear in their instructions to you?
A. That was clearly the understanding at the time.

Now as to what lawyers, there was only one lawyer, Mr. Watkins, in the conference by tele-
[13-118] phone from Harrisburg.

There was another discussion in February about the nature of the results and further delineation of the study, which I can tell you about either now or a little later.

In other words, we defined even more precisely later on the kind of results they wanted.
Q. But in either case there were no constraints put upon your professional investigation or your professional judgment in the conduct and reporting of the study?
A. I can tell you very clearly that we would not have agreed to that study if that was not the condition, that we regarded this as a professional study and I think all of us professionally are bound by these kinds of ethics.

The understanding very clearly was that this was to be a study in which we would not share the nature of the study with other people while the study was going on, but once the study was over that we could always keep copies and, of course, once the study is concluded a professional person has the right to publish his result.

I think that's the professional assumption in a situation like that, the ethical assumption.
Q. Have you retained a copy of the report?
A. No.
Q. Will you describe to the Court the study and
[13-119] your design for the conduct of it?
A. It seems to me that this trial had been going on for a long time.

THE COURT: Me too.

THE WITNESS: If it is all right with you I will hit highlights because, as you know, academic people can go into unbelievable detail, so I will cut it short.

Let me say the study took three months, three months of hard work, of very harmonious — which is not always the case. We got together and we designed the study specifically by taking the charge, as we called it, from Watkins and others and putting them together into a researchable design. There were four essential questions which we attempted to answer.

First, what is the role of an institution in the service-delivery system;

Number 2, is an institution an appropriate educational treatment facility;

3 is Pennhurst an adequate setting; and

4 if not, can Pennhurst be made an adequate facility?

We took those four questions and we drew from those four questions what we call a conceptual framework. The conceptual framework involved looking at and developing several levels of data.

The first level is system-level data. We looked at
[13-120] the Southeastern Pennsylvania system and the UR system in general as it interrelated with other systems.

We looked at the Pennhurst system.

Then what we did is we developed what we called a profile of Pennhurst. The profile of Pennhurst was very complex, so that what we did from the outset was to break down the profile into several additional levels of data.

First of all, the units. We looked at all of the nine units, specifically, their purposes, their organizational structure, and their functioning.

Then we looked at all of the programs and all of the services at Pennhurst. Each one of us was responsible for a portion of the job, so that the job interpenetrated and any conclusions we came to had to be a conclusion that was agreed upon by all three of us in order to maintain an objective kind of study.

BY MR. GILHOOL:

Q. If I may, how did you assign the research and investigative tasks among the three of you?

A. How did we assign them?

Q. Yes.

A. Why don't you let me finish the conceptual framework and then I will tell you how we divided the labor.

Q. Okay.

A. Do you mind?

[13-121] Q. Okay.

A. We looked at the units, their specific purposes, their organizational structure and functioning.

Then we looked at all the programs, all the services.

We then looked at how these programs and services came into the unit or how the people in the units obtain the services.

We then did what we felt was to be the most critical part of the study, which was that we took about a five percent stratified random sample of the population. We designed a treatment sample. In other words, we followed those sixty-five-plus people very closely to see the nature of their treatment at Pennhurst.

Now the breakdown of how we did this:

We visited every unit on the grounds. We visited during the day, we visited at night, we visited in the morning, we visited at odd hours. We visited with escorts, such as Joe Foster and others, and we visited unaccompanied.

We also read thousands and thousands of pages of documents.

Here is the breakdown:

I was responsible for reviewing medical assistance deficiencies and proposed corrections, which meant that I reviewed all the data and spoke with the people who were involved in that aspect of the institution.

[13-122] I also reviewed life safety codes, efficiencies and proposed compliances, very definitely, and those were turned over to the State attorney, Jeff Cooper particularly, on February 9th because the date was highly technical and somewhat beyond our competence.

Third, I reviewed the Executive Committee, the Board of Trustees, and the Parent Association minutes of, oh, maybe the last two or three years and attempted to get an understanding of the total administrative process and particularly the administrative style as much as I could.

I also reviewed the budget of the last few years and gave particular attention to the proposed budget for the coming year.

I also reviewed the institutional correction material, and particularly the effects of the Vecchione decision on the quality of life at Pennhurst.

I also reviewed the personnel matters, including separations, how many people were separated from Pennhurst, why they were separated, the nature of the separation process.

I reviewed several of these very carefully, very precisely including all of the data.

I reviewed the staff profile, the manpower requests, the union status, the recruitment policy, separation policy I mentioned, and civil rights compliance.

[13-123] I also talked to a number of members of the security and police force at Pennhurst.

Demographic data was reviewed by Valaida Walker.

Modality data was reviewed by Valaida Walker.

Programs and activities, we all interpenetrated on that but various of us were responsible for different parts of it. I was responsible for the exit-house program, the town-house program; and in some detail the teams, the nature of the interdisciplinary teams.

I also visited many of the programs, particularly the vocational-training programs.

We took the nine units; each one took three units. In some instances some people visited other people's units for a variety of reasons, usually for replication, validation, and observation purposes.

I reviewed in detail Units, 2, 4, and 7.

I also was responsible for an analysis of the standards of Pennhurst as applied to the standards of the Joint Commission on Hospitalization.

Then I think the best thing to do would be to let other people tell you the various parts of the study that they did, but essentially that's the way it got broken up.

The study was conducted in the months of December and January. I believe we began on December 22nd and we finished some time in February.

[13-124] We submitted two reports. We submitted an interim report on February 9th at a meeting with Mr. Hobbs, Dr. Rice, and Mr. Cooper; and in that meeting what we did is we took one of the many, many documents that lawyers produce, one of these — I am not sure what this is called, but it simply to me was a list of all the civil actions.

The three of us met, went through that line by line, and gave a written response to 168 items.

We noticed that there was a typographic error on the 167th that was repeated twice. That docu-

ment is entitled complaint on the front. It is in the United States District Court. It has a list of people, and it is also called SECOND AMENDED COMPLAINT, class, Civil Action Number 74-1345.

We turned that over to the folks I just mentioned on February 9th. We also discussed it with them and we also gave them additional detail and encouraged questions because we were, after all, their employees.

Q. What was the nature of your comment on those documents? What questions were you asked to answer with respect to that document?

A. We agreed beforehand by phone that what we would do is we would submit a written comment on each item —.

Q. And what was the comment to address? What was the question you were to comment upon?

A. Well, if I am not permitted to give findings, I
[13-125] would be revealing findings.

Is that what I understood?

Q. Were you asked to say whether, on the basis of your study, the propositions of fact set out in a particular paragraph were true or untrue?

A. Yes, essentially that's what we did.

Q. All right. Fine.

A. In some instances we gave a little more detail or we gave a staff ratio or we gave the number of treatment hours or we subjectively-objectively gave our opinion about something.

Q. So that your comment on each of those paragraphs was a factual comment or an opinion, a professional opinion based upon your study?

A. Essentially, factually. If it was an opinion we said so and in some instances we disqualified ourselves.

There are about fourteen items which deal with constitutional law and I think it was slightly beyond our competence.

Q. Now you said that was one of the products of your study?
A. That's a rather brief report. That's only about a six-page report.

The second product of our report was about a 350-page report that we submitted and we also submitted — I think this is what Mr. Watkins mentioned the other day — about a thousand pages.

[13-126] We submitted a carton full of appendices and that must be at least a thousand pages, but the report itself, as I recall, is maybe about three hundred or so pages.
Q. In either of those reports did you offer any advice on the conduct of litigation about Pennhurst?
A. Litigation? You had better spell that out.
Q. You testified thus far in describing your report that you set out to do factual findings and your opinions as professionals.

Did you offer any advice about the conduct of litigation?

Were you asked to offer any advice about the conduct of litigation of a case, of a lawsuit?
A. You repeated the same phrase — conduct of litigation. I don't know what that means.

Conduct of litigation means how do you deport yourself. I don't, quite frankly, know what you mean. I just don't understand the term.
Q. Did you tell either Deputy Secretary Hobbs or Commissioner Rice or the lawyers whom you have indicated participated in some of the conferences how to defend this lawsuit?
A. No.
Q. That was not the subject of any conversation between you and the Deputy Secretary, the Commissioner, or their lawyers?
A. It would be rather foolish to even attempt that.

No, we didn't.

[13-127] Q. Specifically, it was not the subject of any comment in either of your reports?

A. Not with me.

(Photocopy of three-page "SERVICE PURCHASE CONTRACT" between Department of Public Welfare and Dr. Alexander Hersh was marked PARC Exhibit 71 for identification.)

BY MR. GILHOOL:

Q. I show you a document that has been marked PARC Exhibit 71.

Do you recognize that document?

MR. GOLDBERG: Could we see that, please?

MR. GILHOOL: Yes.

MR. STUTMAN: I will give you a copy of it.

THE WITNESS: Yes.

BY MR. GILHOOL:

Q. What is that?

A. This is the written service purchase contract for the consultation fees, the *per diem* fee, and the travel while conducting the study.

Q. This is the contract, in other words, under which you conducted your study?

A. Yes.

Q. Dr. Hersh, you testified that there were four focal questions in your investigation.

Will you kindly repeat those questions and tell us what answers you came to?

[13-128] MR. WATKINS: I assume my objection is noted, your Honor.

THE COURT: Yes.

You may proceed.

THE WITNESS: Do you want me to answer that question?

THE COURT: Yes.

THE WITNESS: You want me to comment on the role of the institution?

BY MR. GILHOOL:

Q. Yes, sir.

A. In the service delivery system; right?

Q. Yes, sir.

Will you tell us for each of the questions what answer you came to, what answers you came to?

A. (There was no response.)

Q. The first question was —

A. The first question was what is the role of the institution in the service delivery system.

The reason I am pondering for a moment is because that is a very heavy question and it is a question which could have been debated, as you know, vigorously.

We pretty much came to the conclusion that the institution has pretty much lost its role, that it is essentially an obsolete way of treating people.

[13-129] It is based on a series of assumptions which are dated. It is based on a number of assumptions like retarded people like to be with one another; retarded people should be separate from the mainstream of Society; in an institution you can pull together under one roof all the necessary services.

There are a whole series of assumptions like that that go back to the 1900s, all of which can no longer be substantiated.

So that the conclusion we came to is that there is no role for an institutional service delivery system in Pennsylvania.

Q. The second question?

A. The second question is is an institution an appropriate educational-treatment setting?

The answer to that is clearly no, the reason being that an institution is a segregationist form of subsociety which dehumanizes people. It reduces the possibility that they can ever function in a normalized Society; and it in no way supports the idea that education and treatment are even possible.

It is essentially a form of segregation which means the needs of Society to rid itself of people who are different, who are special, who are deviant, who need special help; and it is an unsuccessful way of dealing with people.

Q. The third question?

A. The third question: is Pennhurst Center an adequate facility.

[13-130] I said in the beginning that we wanted to conduct an objective study and we wanted to do a comprehensive study. We had a lot of spirited discussion among the three of us. We had some real debates and once in a while we had to tell each other to be quiet, and this is a tough question because there are many, many lives at stake, and thus we did not take lightly the question.

We found in many ways that the staff of Pennhurst were really fine people, they were hard-working people, they were doing their best.

However, we came to the conclusion that because of the essential obsolescence of the total system and because of the complexity of the interpenetration of the various systems — Southeastern Pennsylvania, child-welfare system, mental-retardation system, et cetera, et cetera, that having evaluated all of the factors that we could put our hands on we came to the conclusion that Pennhurst is not an adequate facility.

Q. And the fourth question?

A. The fourth question is also a very serious question because again it involves many, many lives and literally millions and millions of dollars.

Q. What was the fourth question, Doctor?

A. The fourth question was, if not, can it — "it" being Pennhurst —

[13-131] If not, can Pennhurst be made an adequate facility.

We came to the conclusion that it could not, that there is no way that Pennhurst could be made into an adequate facility. It is simply too far beyond repair and there are just literally hundreds of reasons why this is the case, not the least of which is the fact that Pennhurst as the whole structure, the whole way of operating out there is simply too far gone. It is simply based in an earlier model, which is just totally obsolete, so that the answer to that is no.

Q. Dr. Hersh, have you, in the recent past, had occasion to conduct another study of Pennhurst State School and Hospital for the Epilepsy Foundation?

A. I did conduct a study for the Epilepsy Foundation of America, which is located here in Philadelphia. I think it is called the Southeastern Pennsylvania Chapter.

The Epilepsy Foundation was doing a study of Pennhurst in order to develop a model of deinstitutionalization.

As you know, the funding streams nowadays are for the developmental disabilities, meaning mental retardation, cerebral palsy, and epilepsy.

Epilepsy is a very serious social problem in our society which is seriously neglected and the Epilepsy Foundation is very anxious to develop a form of consciousness toward the problem and particularly to do something about all the people at Pennhurst who are not receiving the care they need.

[13-132] Do you want to stop me?

Q. I wanted to ask what portion of the approximately 1254 residents at Pennhurst have epilepsy.

A. There are over 300. At the time of this study I think we figured about twenty-six percent, around 330 people who have had, do have, or there is a very, very good possibility that they will have seizures because of the various clinical pictures.

About twenty-six percent of the population, we figured. That is an estimate.

Let's put it this way — we identified 330 people who are receiving medication for epilepsy.

Q. Will you describe to the Court first the time during which this study was conducted, the design and conduct of it, and your conclusions?

A. Okay.

I was responsible for one portion of the study. It is a complex study which is being done on an interdisciplinary basis.

I was responsible for interviewing fifty people at Pennhurst who were receiving medication —

THE COURT: May I interrupt?

BY THE COURT:

Q. This is in connection with your prior study?

A. Yes. I am now describing the Epilepsy Foundation Study.

[13-133] Q. Very good.

A. I was responsible for interviewing fifty people who were receiving medication for seizures. I was able to interview thirty-eight of them.

I conducted the study in the months of December and January.

My job was to read the records and make some judgments about these people.

What I designed was a study that had three parts to it. I would first read the record, then I would interview the client, and then I would make certain judgments, and here are the judgements I made:

How ready is the individual to leave Pennhurst?

The second judgment is how much has Pennhurst readied the person to leave Pennhurst?

Third, how much community readiness has been developed so that the person could leave Pennhurst?

Then I developed a very fancy sort of rating scale on all three in order to reduce the subjective data into something that would be quantifiable.

BY MR. GILHOOL:

Q. And what were your findings and conclusions from this inquiry?

A. There were a whole string of findings. Let me just hit a few highlights. Okay?

What we found, one of the most intriguing re-
[13-134] sults of the study, one that I hope to continue at a later date, is that no matter how retarded a person is — I reviewed people who were profoundly-retarded, severely-retarded, moderately-retarded, and mild.

No matter how retarded the person is he has an acute awareness of the fact that he has seizures and I took from that recult the very strong realization that no matter how retarded a person is he experiences; he knows what he is experiencing, and he is very sensitive to his own experience.

Having a seizure is a very special kind of peak experience that a person has. Fortunately, not everybody has them.

That was a very important result.

What I also discovered was that epilepsy was not being given such acute attention by either the staff of Pennhurst or by the community.

I found that my rating of readiness of the residents was much higher — was slightly higher than the ratings of the Pennhurst staff, but very, very much higher than the ratings of the community.

In effect, what I am saying is that the communities were doing nothing to help these people leave Pennhurst. They simply are not tuned in to the needs of people.

Q. When you say "communities", what do you mean?

A. BSUs.

[13-135] Q. Base service units located where?
A. Well, let's see. I think most of the base service units that Pennhurst has people from are in the five-county area, so that most of them are from the five-county area.

I should have mentioned earlier in the Pennhurst study for the State we did also samples of the BSUs and the counties' mental-retardation directors.

Maybe some of the others could give you the results on those.

But coming back to the epilepsy studies what we found is that the BSUs were not tuned in, not receptive to the needs of seizures, and not doing anything to get ready to discharge these people.
Q. And by "these people" you mean the residents of Pennhurst?
A. These were the thirty-eight residents of Pennhurst who were having seizures or were given anticonvulsant medication.
Q. Was that finding in the epilepsy study of the base service units in activities for preparation consonant with the study of the findings done by you and your colleagues at Pennhurst?
A. Well, essentially, the findings in both studies would be similar.

Pennhurst does not push the BSUs to develop programs. The BSUs do not push themselves to develop programs.

The county administrators seem to be allowing Pennhurst to die of attrition. They seriously do not
[13-136] give it attention.

There is a lack of camaraderie and there is a lack of — I shouldn't say camaraderie. There is a serious lack of interested partnerships between the BSUs and Pennhurst.

There is a great deal of confusion about the role a BSU should take when it has a resident living at Pennhurst, many, many confusions about it.

They don't know whether they should be parents, advocates, or visit or treat or whay they should do, so there is much confusion.

As a result, what happens is that the people at Pennhurst feel very put upon and very angry at the BSUs for good reason because people are sent there, simply dumped, and then Pennhurst is left to treat them on their own.

The people in the BSUs feel overwhelmed by the need for service in the community, so they put the people at Pennhurst on the bottom of their priority ladder, so what you get is a picture where each is missing the other and it is a system which is not working.

We also discovered that there were $18 million missing.

Q. Would you speak to that, please?

A. Well, in our study we found that there were $21 million allocated to community funding and we saw evidence of about three or four million spent.

[13-137] But we couldn't find out what happened to the rest of it. I know I don't have it because I haven't gotten paid yet.

Q. Dr. Hersh, based upon your work in the course of both of these studies, in your opinion is Pennhurst the least restrictive environment possible for the care and habilitation of its residents?

A. I would just answer that by saying that it is the most restrictive environment.

Q. Is that true for each of Pennhurst's residents?

A. Each of Pennhurst's residents.

* * *

Q. On the same basis, have you an opinion, Dr. Hersh, is Pennhurst the least separate environment possible for the delivery of care and habilitation for Pennhurst's residents?

A. No. I think it is the most restrictive. What it does is that it takes people out of their normal — an opportunity for some normalized existence — and segregates them and moves them to a location which is so far from their families that it literally disrupts normal family relationships.

Q. Does your opinion in that regard with respect to the least restrictive and the least separate, obtain for
[13-138] each one of Pennhurst's residents?

* * *

THE WITNESS: I think what you do is you believe in a couple of things.

First of all, you believe in what you see. We observed Pennhurst for hours and hours and hours and hours and hours. We saw a lot that was good. We saw some lovely programs, we saw some dedicated people, but we didn't see enough of them.

We saw a lot of people sitting and milling, who were badly dehumanized, and some people who had become very troubled people as a result.

Number 1, you believe in observation; and,
[13-139] Number 2, you believe in random sampling.

If you evaluate very carefully a sample you assume that that sample represents the whole to that extent, so that I would have to say that for the most part it is not a very conducive setting.

I hope you understood my qualification when I said that there were some good programs there. There are just not enough of them and I don't think it is possible that there ever will be.

By MR. GILHOOL:

Q. Did you see anyone in Pennhurst in forming your opinion for whom it is necessary because of his

handicap or her handicap that care and treatment be provided in such a separate and restrictive environment?

A. I can answer that by way of showing you the conflict that arises in a person when you go to a place like Pennhurst.

After spending several weeks there, one night I couldn't sleep and my wife asked me what the trouble was. I said that for the first time in my life I had allowed myself to examine what the meaning of euthanasia was, that up until that time in life I had always pushed away that question, that I couldn't bear to think about euthanasia and as a result of spending a lot of time at Pennhurst I one day or one night asked myself wouldn't these people be better off dead because this is really not an existence.

[13-140] Q. How did you answer that question?

A. Well, I don't believe in euthanasia except for maybe somebody who has cancer and is ninety-five years old and knows they are dying and has set up a kind of living will and he knows what is happening.

I certainly don't believe in it for people who are mentally-retarded. I believe there are lots of mentally-retarded people, but it was a very painful kind of thing to experience at that study.

I would have to add another slight qualification, and that is that I would find it very, very hard to move some of those folks out there who have been there for forty years and are in their seventies and eighties. It really wouldn't be very fair to move them, but they are a very small percentage.

But I would not like to see anybody admitted to Pennhurst any more, which is my way of answering your question, if that is acceptable to you.

MR. GILHOOL: I have no further questions.

* * *

[13-154] BY MR. WATKINS:

Q. Doctor, is it fair to state that your position is that institutions the approximate size of Pennhurst, the age of Pennhurst, and so forth *per se*, can't do the job that they are set up to do?

A. I think there is no question about it. That was my earlier testimony, that I felt that way.

Q. And how long have you held that view?

A. I hold it more today than I did in December of '76.

I found myself remarkably open at the beginning of December. When I took the job I was willing

[13-155] to give it a fair shake.

I became more and more concerned as the study progressed. I also visited some other institutions just to test out my own objectivity.

* * *

[13-158] BY MR. SACKS:

Q. In your testimony you have made a couple of allusions to the BSUs. In fact, I think you said Pennhurst doesn't push the BSUs.

I'd like to know what kind of study you made and when and where, in your concern with the BSUs.

A. As part of our study, what we did was to take a random sample of the BSUs in the five-county area and we established what we called a standardized outline and we, by way of telephone, called the BSUs and conducted the telephone interviews.

The interviews lasted a half hour to forty-five minutes. They were free-flowing with some degree of focus on questions like how many people have you placed at Pennhurst? How many people are you now responsible for at Pennhurst? What is the na-

ture of your relationship? What do you see as your role in relation to admissions, ongoing, and discharge — questions like that.

The results were fairly clear. The people in the BSUs were more than willing to give us any information we wanted. They had been alerted to our phone calls by Dr. Rice, so that they were perfectly willing to discuss this with us.

[13-159] Q. And there was no face-to-face confrontation and your questions were more or less generalized, nothing specific?

A. No, no, but we did have access to records and in our interviews at the units we were always able to cross-validate by reading records and seeing how much contact the BSUs had; and we were also able to talk to the staff of the units to assess how many visits and how much contact there had been, so we had a replicating process.

Q. Did your questions with the BSUs involve the life-management plan that the BSUs developed for each resident at Pennhurst and how often they update this?

A. Yes. That was one of the questions.

Q. And what was your more or less general response? Do you remember that offhand?

A. The BSU response?

Q. Yes, to the life-management plan.

A. Yes. The life-management plan for the most part is *pro forma*. They just go out there and they run through a life-management plan, or what they are more apt to do is to utilize the Pennhurst reports to fill out their own life-management plan form, so they are just going through the motions.

* * *

Testimony of Valaida Walker

* * *

[14-5] Q. Were you in the courtroom yesterday and did you hear Dr. Hersh's testimony with respect to the four focal questions of your inquiry?
A. Yes, I did.
Q. Did you and do you join in his statement of your answers to those four focal questions?
A. Yes, I do.
Q. Will you tell us, please, what were the conclusions of your study and, in particular, what were the recommendations to which you and your colleagues came?
A. Okay.

We, unfortunately, didn't have our notes and what we did was the three of us got together and recalled as much as we could our recommendations, so they may vary a little bit from the content of the report, but they are our recommendations at this point anyhow.

The first recommendation would be that there be no new admissions to Pennhurst.

If I may, I'd like to speak to each one of the recommendations.

[14-6] Q. Continue.
A. As you know, some years ago commitments were stopped, admissions were stopped at Pennhurst, but the courts continued to court-commit people and we felt there had to be a mechanism where the court could not commit anyone to Pennhurst any longer.

The second recommendation was that no additional funds be spent in Pennhurst. We recognize that there are a lot of — there is a need for additional staff and that Pennhurst has requested additional staff to bring the standards up as far as medical as-

sistance and also JCAH, and also that there are additional renovations needed to bring it up to late life-safety codes.

But we are recommending that none of these funds be spent because our third recommendation is that all of the residents from Pennhurst be discharged to the base service unit and that money spent to upgrade the programs and to upgrade the buildings would just be money down the drain.

Our major recommendation is that all of the residents be discharged back to the base service unit and that there be a mechanism in the community to service them. We feel that legislative modification must be made to allow funds to follow the residents into the community.

In other words, right now the system is such that Pennhurst, as an institution, gets the funds and there must be some sort of mechanism for funds to
[14-7] go from the institution into the community and follow the residents.

We also are recommending that along with this, in addition to our concern for the future of the 1200 residents in Pennhurst, we have a great deal of concern for the staff that is there too. There are 1700 employees there and just, you know, to send all of the residents back into the community and leave no jobs for the employees is quite — is something that if you have a human touch you have to be concerned about.

So another recommendation we have is that there should be some provision made at the State level to permit the State employees to transfer to the base service unit and community without any loss of benefits and with their same status.

The fourth recommendation was that the New Horizons Building and the modular buildings on Pennhurst be donated to Chester County to be used

for their community services, such as drug abuse, alcohol, or whatever; but that they no longer be just mental-retardation facilities, but that they have access to the buildings and can use those to develop programs in them as they see fit, and that the remainder of the buildings be turned over — either be demolished completely or that they be turned over to some community group, such as a community college, or office buildings, so that they are not used or can never be used for an institution again.

The sixth recommendation is that the name of
[14-8] Pennhurst be abolished completely and never be attached to any part of the facility whatsoever for obvious reasons.

THE COURT: May I interrupt to ask you a question?

BY THE COURT:

Q. I believe one of your recommendations is that all of the residents be transferred to some community-based unit.

If I remember correctly, and I may be wrong, Dr. Hersh yesterday, I believe, when he made a similar recommendation, said something like except those older people — I don't know exactly how he put it.

A. He did.

Q. I just wondered how you felt about that because I notice that your recommendation is that everyone be transferred to some community service.

Do you, yourself, see any reason why some of the older residents couldn't find happiness in the community?

A. No, I don't, Judge, and I disagree with Dr. Hersh on that point.

Q. That's very interesting now because you said you agreed on all your recommendations, but they

always say that that's somebody's prerogative — to disagree. I don't know.

A. Well, the recommendations are consensus, but within each one of us we came to a point on which we agreed.

Q. On the major recommendations?

[14-9] A. Yes.

Q. I realize that. All right.

You do think then that the community somehow or other should, in your opinion, absorb these older residents?

A. Yes, I do. Yes, I do.

Q. I was lucky enough to be raised in a small suburban community where before normalization came in vogue they practiced it.

I can remember going to the corner grocery store and seeing a non-verbal, profoundly and seriously-retarded youngster helping in the grocery store.

I can remember in school there being a janitor's helper and everybody knew you didn't take notice to Ernest because Ernest couldn't read and it wasn't until later that I realized that Ernest was mentally-retarded.

But, as I look back on it, many of our people were absorbed in the community and they were part of the community.

Now maybe a suburban community is atypical, but I can cite an example of where I live. I pass a corner where there are five buses that intersection and during the summer a group of mentally-retarded individuals move into a foster home in the neighborhood and I was rather worried because I would see them standing on the corner waiting for the bus every day and having taught school and

[14-10] knowing how school kids can be, I wonder, when

school comes, are the kids going to tease them and I would drive by.

For a couple of days they would look at them very strangely and oddly, but within a month it was very interesting because they are holding umbrellas for each other and they were totally a part of that bus crowd and they were integrated and these were older people.

I learned later that some of them had been removed from Pennhurst and were living in a foster home in the community, so I am not thinking it can work, I have seen it work and I am convinced that it can.

BY MR. GILHOOL:

Q. Dr. Walker, similar recommendations to replace Pennhurst with community services have been made as long ago as 1970, have they not?

A. Yes, they have.

Q. And, indeed, as long ago as 1970 some $21 million were available precisely for that purpose?

A. Yes.

Q. In your opinion, based both upon the recently-completed study of Pennhurst and your experience otherwise with the mental-retardation system or non-system in Southeastern Pennsylvania, why, at the bottom line, has this not happened?

A. Okay. Well, I think that there are three parts there, I think there are three aspects.

[14-11] I have really given this a lot of thought and I think that the system is very much to blame. The duality of the system which allows the State — and the law is very clear in the Mental Health — Mental Retardation Act — that the State is responsible both for institutions a hundred percent and the community is responsible for one aspect.

But the funding has not been equal at all, so the duality of the system creates problems and also pro-

vides no incentive for the communities to develop any kind of facilities. It is easier for the community to commit somebody to an institution than to try to develop a community situation itself.

Secondly, I don't think there is any clearcut responsibility. In having been a regional commissioner I remember reviewing the budget of counties and not really having any responsibility to make sure that they were followed through on their suggestions, which leads to the next problem of the political implications of the system, where counties' base service units would contact people at higher levels, even on the political and legislative spheres, to undermine the kinds of things that were being done at the higher level.

I think one of the problems — and as long as I have been in the system I have never known an institution to close — as soon as they talk about or they begin to uncover horror stories in any kind of institution it is quickly covered up and unions begin to fight for their turf.

[14-12] It is really not the residents that are involved at all. It is the constituents of a legislator who put pressure or constituents of legislators or unions moving to force the continuance of a very, very bad system.

So I think that one of the recommendations that we made of transferring labor to the community might avoid such a situation in the future.

Q. Has such a plan for assuring jobs in the community, indeed identifying which jobs they shall be and arranging the transfer, ever been put together by the Commonwealth?

A. I can remember when I was in the department we suggested it, but there was never any plan and the suggestion was laughed at as really not being enforceable or becoming a reality.

I think that Pennhurst is somewhat to blame because of the same job stability, the continuance of status. Everyone is afraid to really accept change.

When I look at the philosophy of Pennhurst, it says that it is temporary placement.

Q. By "philosophy" do you mean that written one-and-a-half-page statement?

A. Yes. It is to be temporary placement; but, in fact, because of the staffing pattern, because of the lack of staff and all of the other kinds of things — and I have to hasten to add that we saw many, many dedicated staff, but the system really does not allow for
[14-13] staff to train the residents for temporary placement with the flowback into the community, so I think that there is a survival mechanism that certainly is a psychological survival mechanism that some of the staff need to have.

Worst off is the counties and the base service units and I also have to hasten to add that I am sympathetic with some of the problems of the base services units the counties have and I feel that many of them have done a better job than others.

I think that there has been a lack of trust, and again I am speaking from experience. I can remember in 1973, when the Family Services Resources funds were made available to the counties. The counties were very reluctant to use them for the units. A lot of it was turned back to the Department of Public Welfare at the State level and in my position as regional commissioner I was pushing people to use these funds.

Q. What were those funds? What was the Family Resources funds?

A. Well, they were used — as Mrs. Bowman testified what she needs is a babysitter sometimes and she would not like to have her daughter institutionalized, but the strain of having someone to be home

all the time, every day, and never being able to go out like a normal family, is very hard.

So the Family Services Resources funds were made available to provide such services — transportation, babysitter services, and whathaveyou — and the base service units in the counties were reluctant
[14-14] to use this because in the past the State has developed programs, given money, and then taken the money back and then the county and the base service units have begun to provide a service and then are left high and dry and are the bad guys in the situation.

So we, you know, had difficulty in selling them the idea. In many cases what also happens is that restrictions are put on the use of the money and the counties and the base service units don't have the discretion that they need to have to provide the kinds of services that are needed on the community level.

I think part of the problem with the base service units is lack of interest. I came into the department in 1972 and it wasn't until 1973 that there was even a commissioner, one person in each region, that was assigned to mental retardation and I don't really want to get on my soapbox, but the whole emphasis has been on mental health and it still continues to be mental health.

There are twenty-seven base service units in this Southeastern Region and there are seven who still carry the name of a mental health unit and don't even include mental retardation in it.

This is symptomatic of their idea that mental health, drug abuse, and alcohol somehow are more popular kinds of things to deal with and mental retardation is less understood and has much more of a
[14-15] stigma attached to it, as they see it; and, therefore, is the stepchild as far as services are concerned.

Q. The base service units receive certain funds which are earmarked for mental retardation, like the Family Resources Service funds; is that correct?
A. Yes — well, the counties receive a budget, which then is divided among the base service units, but they have the discretion of the division of that budget.

The family services, Family Resources Services, is a lump sum that is given to the counties.
Q. But the bulk of the money received by the base service units in the counties is given to the base allocations?
A. Yes, and that goes to personnel rather than services.

THE COURT: May I interrupt and ask a question?

BY THE COURT:

Q. Would you mind telling us on the record what a base service unit is?
A. Okay.
Q. I mean everyone uses that term and —
A. Okay. A base service unit is, according to the Mental Health-Mental Retardation Act there are geographic locations which encompass a population between 175,000 and 200,000 people and that is called a catchment area; and each catchment area of that population must provide a base service unit, which provides certain services to the residents in that catchment area.

[14-16] Some of those services are diagnostic, evaluation, referral, emergencies.
Q. Are these boundary lines for the base service units contiguous with the counties or do they disregard the counties?
A. In the Southeastern Region of Pennsylvania we are so heavily populated that they are contiguous within counties, so that Bucks would have four base service units; Philadelphia, thirteen if my figures

are correct; Chester would have a number, but in Upstate Pennsylvania, where you would not have 175,000 to 200,000 in one county, one base service unit may include three or four counties.

But this is the nature of our population.

Q. So that if I understand you correctly the base service unit was set up under the Mental Health and Mental Retardation Act?

A. Yes.

Q. And is it funded directly by the Commonwealth or is it funded by the counties?

A. The county puts in some money, but the money flows from the State.

Q. Are the employees of the base service units considered county employees or are they considered State employees?

A. They are considered State employees — county employees, but there are specific guidelines that must be adhered to by the State.

[14-17] Q. You say they are considered county employees?

A. County, county employees.

Q. And the funding of the base service unit, as I understand it, comes directly from the State appropriation?

A. Yes, it does.

Q. Do the counties provide any part of the costs of operation?

A. Yes, they do. Yes, they do.

Q. Do you know what the formula is, if there is one?

A. Well, for some services it is ninety-ten and for some other services the county puts additional money.

Philadelphia County, for instance, I also believe gets additional funds through United Fund and some other kinds of agencies.

Q. All right.

Now I am going to go back and, if you know, did Act 256, which you know, which it has been testified here is the act pursuant to which there was appropriated, I believe $21 million —

A. Yes.

Q. — for the establishment of county facilities to take care of the problems that we have been discussing here in this court.

A. Yes.

Q. If you know, under the mechanism was that money appropriated to the department in Harrisburg or was it appropriated for the use of the base service units or who has control of saying well,

[14-18] here's $21 million, we are going to give $4 million of it to the base service units in Bucks County?

Who gives that, if you know from your experience? I see that you had participated in government and if you know from that standpoint.

A. The office of the Department of Public Welfare in Harrisburg was responsible for the allocation of that money for the Southeastern Region. The region did approve — we sat down with the counties and helped them allocate how much will go to each of the counties based on the population and their needs in returning people to Pennhurst.

That allocation was made and the counties were then to determine how they would use the money. One of the steps was that they would have a public hearing and that the public would help them decide what kinds of services were to be provided for that dollar amount.

Q. So, in effect, the use and allocation of the money was in the hands of the Department of Health and Welfare?

A. The Department of Public Welfare.

Q. The Department of Public Welfare?

A. Yes, but the counties and the base service units, after it was determined what amount they had, had

to go out and secure the building and then get approval from the Department of Public Welfare.

So a great — a lot of the problem was that there
[14-19] was again apathy in the base service units for finding properties.

I remember during my term of office as Commissioner of Mental Retardation that it was very, very difficult to get the counties out to look at places for group homes, to really decide what their needs were, and to really go about the business of finding community placements.

Of course, it is my opinion that it was much easier to continue to admit them to Pennhurst than to go into community-based services.

The record reflects that in 1970 this money was allocated. It is 1977 and we still are not nearly off the ground in terms of services.

The records also reflect that the number of people, the places, the slots that are going to be in the community are 2,000 and that if you empty Pennhurst there would certainly be day kinds of services and support services available for every person put back in the community.

BY MR. GILHOOL:

Q. Dr. Walker, Dr. Hersh spoke yesterday of ships passing in the night and you have just testified to the failure to locate in any single person or office the responsibility and the power to get it done, to replace Pennhurst with community services.

A. Yes.

Q. What, if you will forgive the redundancy role, has that failure of identifying responsibility played
[14-20] in the failure to accomplish the objectives and the plans set seven years ago?

A. Well, as Dr. Hersh said, it is like ships passing through the night. No one has any responsibility.

You say in accounting here you have X number of dollars for group homes, you have it here, please get going.

That's all you were saying — please get going. If they don't get going you would turn back that money and you might have people who need services who don't have services available.

One of the problems also, and I still think it exists, was that group homes and community-living arrangements in the beginning everyone wanted to plan programs for the nice, mildly-handicapped individual who probably shouldn't have been in an institution anyhow and really didn't intend to provide community services for the severely and profoundly and the moderately-impaired.

The community has to gear itself up to being able to accept some of its problems and not feeling that a person who has a behavioral problem must be institutionalized.

You know, from my experience in teaching and in a variety of things there are lots of kids that have behavioral problems, that once they have a problem don't get shoved away in an institution, and we have to learn that mentally-retarded individuals also are going to have behavior problems and we have to learn to cope with it.

[14-21] I know I skirted the question and didn't answer it.

What we really need is authority vested in some individual or individuals and it is my opinion, completely removed from the political system.

Q. Dr. Walker, based upon your recent study and your previous experience with the mental-retardation system in Pennsylvania, in your opinion is Pennhurst the least efficient environment possible for the care and habilitation of these residents?

A. Absolutely not.

Q. Is it the least separate environment in which appropriate and effective services can be provided for the mentally-retarded?
A. Absolutely not.
Q. Is there anyone at Pennhurst who would not benefit from services provided in a more integrated community setting.
A. It is my opinion that all — all residents at Pennhurst could profit from a more integrated normalized setting in the community.

* * *

[14-33] BY THE COURT:
Q. Do you have any opinion right now?
A. [MS. WALKER] Do I have an opinion?
Q. As to how long it would take to move everyone at Pennhurst who is a resident to the type of facility in the community which would be most beneficial to that individual?
A. Your Honor, I think if you had someone who was responsible for the movement and saw to it that it was implemented, that it would not take more than a couple of years to accomplish.
That's my opinion.
THE COURT: You may proceed.

* * *

Testimony of K. Thurman

[14-56] Were you in the courtroom and did you hear Dr. Hersh's testimony as to the four focal questions of the study's inquiry and the study's answers to those questions?

A. Yes, I did.

Q. Did you and do you share in those answers?

A. Yes, I do.

Q. Were you in the courtroom and did you hear Dr. Walker's testimony as to the six recommendations from the study?

A. Yes.

Q. Did you and do you join in those recommendations?

A. Essentially, I do, yes.

I would probably make certain modifications of certain issues; but essentially, yes.

Q. Let me ask you, if I may, to describe the findings of the study as a whole, first with respect to the physical and psychological environment of Pennhurst State School and Hospital; and, second, with respect to habilitation or not at Pennhurst State School and Hospital?

A. Yes.

Well, in terms of physical and psychological environment, I think what we find at Pennhurst is

[14-57] something that we find fairly typically at any large residential facility serving a handicapped population, that is, we find many dehumanizing sorts of conditions, and I might list a few of the more apparent ones.

For example, we find open bathroom stalls repeatedly as we go on every ward. This is not something that's unique to one ward, but rather common in every ward.

Bathroom facilities.

We find lack of toilet tissue throughout the institution. In some cases and in some areas we found

feces smeared all over the toilets and in the walls of the stall.

We entered one ward, for example, one evening and all three of us were on this particular unit or actually ward, to find a number of middle-aged and rather elderly gentlemen sitting in a series of potty chairs right out in the middle of the ward, with urine spilled on the floor, I would assume for some of the gentlemen who didn't quite make it to the chairs in time and so forth.

On this same ward, another instance of a very dehumanizing sort of situation, we found a gentleman lying on the floor who had apparently fallen out of a wheelchair. We were in this ward at approximately 7:15, 7:30 in the evening, somewhere in that time range, and we found this gentleman lying on the floor and walked up to him and asked him how long he had been lying there and he said well, since before dinner.

* * *

[14-58] THE WITNESS: We lifted this gentleman into — back into his wheelchair physically, the three of us, and proceeded at that point out of the ward.

Other instances of what I would call dehumanizing conditions would include on several instances where I visited woman's wards. They had nowhere where they could undress without me viewing them and I was invited back on one of the wards to one of these dormitories and found several women sitting, either partially clothed or naked, on their beds, and yet I was invited to kind of come in and walk through and just generally do whatever I wanted to do in terms of my own observing.

[14-59] In terms of other kinds of physical and psychological conditions, and I really, in a sense, have a difficult time separating those two, we found on another ward — what I am trying to report to you now are specific things which I personally observed.

I think that there can be other things which Dr. Walker and Dr. Hersh could have added.

BY MR. GILHOOL:

Q. Please feel free to state the findings of the report as a whole, and let me say that I am correct, am I not, that the three of you, pursuing your individual and joint assignments, then shared your information?

A. Sure.

Q. And together prepared the findings of the study as a whole?

A. Yes.

Q. And these recommendations.

If that's correct, then please feel free to state your findings, the findings of the study as a whole with respect to the physical and psychological environment.

A. Okay.

At a more general level we found Pennhurst to be an inhumane place to live and found really, in our opinion, no way that we could see to ever make it an adequate place to live.

In terms of programming, and we had some debate about this simply because some of the things
[14-60] which are defined as programs we professionally would question whether or not one would consider that a program.

For example, some of the residents who had run through various behavior-modification programs to learn dressing skills or tooth-brushing skills, were then considered to still be on what was considered a maintenance program because some ward attendant would come in in the morning and check off the fact that that person had or had not brushed his or her teeth.

Professionally, as a special educator, I have a difficult time calling that a program.

The reason I am bringing up this issue is even

including that kind of time as programmatic time, in other words, taking anything that Pennhurst referred to as a program, one of our findings is that at best, at the very best, and I think this is a high estimate, the residents are getting somewhere in the vicinity of forty-five minutes to an hour's program time a day on the average.

I found no one, except those children who attended the Chester County Intermediate Unit, who received more than about three and a half to four hours of programming a day. But this was not, certainly not, the average.

If you would factor out several kinds of programs which we would consider not really programmatic in the truest sense of the word, we were probably talking about something closer to a fifteen-minute average per day.

[14-61] In terms of the quality of programs, I think that some of the programs are quite good in theory in terms of what they are trying to do.

However, they don't have the staff. More specifically, they don't have the staff-to-resident ratios that they need to properly carry out those kinds of responsibilities.

In terms of physical environment our findings were in general that the buildings, while most of them I have to say were relatively clean, they were very stark in appearance, very little decoration on most of the buildings.

In some cases we had people eating, sleeping, and recreating in essentially what was the same room, which was a room which was divided by, you know, rather inefficient partitions.

In other cases we had people milling about in what was considered kind of the day-room area and essentially locked out of their own bedrooms because of various kinds of regulations or policies which required that that be done.

We also had buildings, a number of buildings, where supervision, because of the physical layout of the building, was essentially impossible.

One ward in particular that I visited, for example, and I will give this as an example, was an L-shaped ward, where at this end of the L is where the day room and the television are, which is the most
[14-62] common activity that one finds in any mental-retardation facility. They were located there and there is where most of the residents tended to congregate with the ward attendant, right here.

At this corner of the L was where the office was, so that if someone entered the office, that is, a staff person entered the office, they literally could not see down that hallway.

In addition, coming down the other arm of the L were bedrooms, which meant that if one or two of the boys on this unit went back to the bedrooms for privacy or for whatever other reason, they were essentially — there was essentially no way that they could be observed or monitored in any meaningful fashion by the staff either from the office or from the other end of the ward at the day-room end of the unit.

Again, this is an example, but the environments in general were large dormitory-type of arrangements with anywhere from fifteen to thirty residents per dormitory unit, with rows of beds to which individual residents were assigned.

Typically then there was a day room and some type of eating and/or recreation area.

There were exceptions to that.

Q. Given the physical and psychological environment that you found, did you make findings about the quality of the interaction between residents and staff?

A. Well, the quality of interaction in general, be-
[14-63] cause of the numbers of people that are trying to be

dealt with, cannot be very great quantitatively, and I stress quantitatively because if you put one person with thirty other people, and this is probably as true in a first-grade classroom as it is in a mental-retardation institution, and it becomes difficult to individualize attention.

However, with the retarded populations that we are talking about we need actually more individualized kinds of attention and input.

Qualitatively, I think that a number of staff interactions, which showed on the part of the staff, I think, a real care and a real dedication and a real desire to try to do something for these people who they were in charge of.

I think it is a quantity kind of thing and in some cases a qualitative kind of thing; but generally I have to reiterate my colleagues and say I think most of the staff that I came in contact with were dedicated, caring people, but were overwhelmed in a sense with the tasks created by the institutional structures and systems.

Q. Did you make any findings with respect to the growth of residents or their regression?

A. Well, not specifically in terms of regression.

We did look, however, at program plans for every individual and tried to determine from these the adequacy of the plan for habilitative purposes and
[14-64] our findings in general were that the plans were so nondescript and general in nature that one could easily infer that given this plan it is doubtful that there would be much in the way of progress towards the kind of specific goal.

For example, one annual program review goal that I read was for So-and-so to reach his maximum potential.

Well, that, essentially, says nothing in terms of what we are going to do programmatically for an individual.

It would seem to me that the basic underlying philosophy of any educational and habilitative program would be to bring whoever was benefiting from that program to his or her maximum level of potential.

I found it very difficult in the record that I looked at to assess progress primarily because some notable exceptions became implemented by the DAPT team.

There is no systematic way of that being used. I shouldn't say there is no systematic way. There is no systematic way it can be employed to measure ongoing progress in the residents.

That, coupled with the rather nondescript and general kinds of goals that you tend to find in annual program reviews, would lead one to believe that most people were not making much in the way of definitive progress towards goals.

Q. Let me recite three findings which are in evidence in the record before this Court and ask if your own study is consistent with these findings.

* * *

[14-65] I am referring to the testimony of Dr. Betty Hare and Dr. Flueck and the exhibits that were received therein.

My first reference is to PARC Exhibit 53, Table IV, which shows that upon a review of a one-in-ten sample of records of Pennhurst residents, in thirty-four percent of those records there were explicit affirmative notations of record on the part of the residents in skill and performance, but second, and perhaps my colleagues can provide the exhibit table citation, for Mr. Goldberg, the second finding was an absolute diminishment in social age score on the Vineland for nearly fifty percent of the residents at Pennhurst who had two Vinelands over a period of time, and the third was for eighty-seven percent of

the residents a drop in social quotient between Vinelands.

BY MR. GILHOOL:

Q. Now are those findings consistent with the findings of your own study?

A. I would say yes, they would be, but I must
[14-66] qualify it by saying that we did not look at those reports for Point A and Point B in terms of a score as a specific score on a Vineland or other scales of adaptive behavior.

* * *

Testimony of Elsie Schmidt

[14-107] Q. Mrs. Schmidt, you are the president of the Pennsylvania Association for Retarded Citizens?

A. Yes.

Q. And you have been president since 1975?

A. Correct.

Q. Will you tell us when your activities with the Pennylvania Association began and what positions of responsibility you have occupied in the organization?

A. My position with the PARC began six years ago when I went to the Executive Committee of PARC. I have been on the Executive Committee for six years.

In 1972 I was given the charge of chairperson of the Education Committee to sustain the implementation of the right to education.

I then served as one of their regional vice-presidents, served as a senior vice-president; and then, in '75, took the presidency.

I have also, on a local level, served as a local chapter president. I have served for four years on the local MH and MR Advisory Board in the capacity of vice-chairman, chairman of the Planning Committee, and have served on the Evaluation Committee.

Q. Is that the Board of Westmoreland County?

A. Yes, sir, and I have also been and I am also a member of the Board of Trustees of the Ebensburg State Center.

[14-108] Q. When did the Pennsylvania Association's attention to Pennhurst originate?

A. I think it is a fair statement to say that there has never really been a time in past history when the focused attention has not been on the quality of life at Pennhurst.

As a matter of fact, PARC was founded right here in Philadelphia in 1950. The early leadership and members of the organization were parents of children who resided at Pennhurst. They were concerned with the kind of care and service they received.

I am the thirteenth president of PARC and all the other presidents have been concerned with the quality of the care at Pennhurst.

Now, twenty-seven years later, I am still to be concerned with the establishment of a full array of community services as alternatives in lieu of placement of persons at Pennhurst.

Q. Why, Mrs. Schmidt, does the Pennsylvania Association for Retarded Persons exist?

A. Well, generally speaking, we exist to promote the welfare and rights of all mentally-retarded people but if we go back to that early beginning we exist for the purpose of finding a community alternative, the answer to placement in institutions.

We are looking for those alternatives to be funded by public agencies so they can do the job, so
[14-109] that parents will no longer have to be concerned.

We come to this time in the history of our organization, we now see that we are in existence for another reason — to protect the rights of individuals.

We also have the responsibility to monitor what we initially created and hopefully will become a future for our mentally-retarded people.

Q. Around 1967-68 did Pennhurst become a still more intensified focus of attention and activity by the Pennsylvania Association?

A. Yes, it did, sir.

Q. Would you tell me why and the developments around that focus?

A. Well, while we were somewhat successful in establishing community services in the area of educa-

tion and vocational training at the same time, along with our parallel activities, there was still the counsel of professionals who encouraged parents to place their children in institutions.

By 1967, which was only a year after the advent of the MH and MR Act, we were alarmed with the conditions at Pennhurst — overcrowding and understaffing.

I can still remember vividly the incident that brought the Pennsylvania Association for Retarded Citizens — at that time it was Children — to agonize over an incident that I would like to relate, if I may.

* * *

[14-110] BY MR. GILHOOL:

Q. Mrs. Schmidt, would you tell us of the event that gave rise to PARC's intensive activity around Pennhurst in 1967-68 and what followed therefrom?

A. In '67 and '68, the PARC residential chair was chaired by a young lawyer, the father of a child, Dennis Haggerty.

He received a call from a mother who had re-
[14-111] ported to him when she went to visit her child at Pennhurst. She discovered that the child had been dead for three months.

She ran back to the ward where the child lived to find out what had happened and she had been told that her son had died in a fire.

MR. WATKINS: Your Honor, this is hearsay.

MR. GILHOOL: Your Honor, it is not offered for the truth of the story, but rather for what followed therefrom, and I will certainly —

THE COURT: We are taking it as the basis on which certain parents got together and formed an association.

BY MR. GILHOOL:

Q. Did the Pennsylvania Association, following the report of this event, undertake an intensive investigation of Pennhurst?

A. Yes, sir, we did.

Q. And will you tell us of that investigation and of what activity and developments and efforts came out of it?

A. Well, I would say, if I can, that for the first time we got into a little bit of the government work and this investigation because we wanted to look at what were the number of factors that might have contributed to the poor conditions at Pennhurst, what probably might have been the problems.

In the course of that study we discovered that there were a number of things that contributed to the Pennhurst ineffectiveness.

[14-112] The first thing we discovered at that time were the wages paid to attendants. We discovered that they were little more than what was paid to people on public assistance.

So we at that time urged the employees to unionize. We felt that it was time for them to challenge for more wages, it was an opportunity to recruit more-qualified people and also to recruit professionals.

One of the things that we discovered was that there was a law requiring that superintendents of institutions be physicians and psychiatrists. We found in many instances that physicians, those who were eventually recruited in their position as superintendent, often were those physicians who were not able to make it in the community.

Psychiatrists, we discovered, knew little about mental retardation or the whole side of the developmental aspect of the child, so we were able to influence a law change.

We have now heading all of our institutions in Pennsylvania our developmental specialists.

We discovered other things. There were policies and I think it was Mrs. Bowman or one of the other parents who mentioned here in the trial that we were not permitted to visit the back wards where the children slept and ate. We were able to influence a policy change for an open-door policy; the parents may come and go as they felt necessary.

* * *

[14-113] We discovered that there was almost a total absence of programming at that time in '67 and '68. We found out that ninety percent, ninety-eight percent, of the residents at Pennhurst had never had the benefit of educational training.

As a result of that we looked at that problem very, very seriously — what impact could we have on bringing immediate programming to the residents of Pennhurst.

It was the association's choice to seek the right to education for all children. We felt that was the best system and the immediate system that we could tap into to bring results, especially to those children presently residing in institutions and those in the community who had not formally been served or were not being served appropriately.

We went about what perhaps may have been our greatest impact in the way of helping at Pennhurst.

So, in summary, we did numbers of things at that time, hopefully that they would be remedied

and that we could see some improvement at Pennhurst.

Q. Let me focus particularly on act 256, the money and the plans for the replacing of Pennhurst with community services.

[14-114] You have testified that despite the act that has not happened. Why has it not happened and what has PARC sought to do about that fact?

A. Well, we have been distressed over the fact that nothing has happened with the money appropriation from Bill 256. Orginally. it began when the act was passed that we were part of the group in the development of Phase I of the development of the plan to implement the moneys in Act 256.

At the end of 1972 there has been a suggestion of further litigation, negotiation, that we possibly could get that money to be used appropriately; and we had to stress that financially we would not be able to achieve the benefits of that $21 million.

Q. Have you had occasion over the years beginning in 1971-72 to meet with responsible State officials — the Secretary of Welfare, the Governor and the rest — to complain about what's not happening and to make recommendations?

A. My involvement in PARC has caused those kinds of activities beginning from '73, '74, and so on.

We have had numerous meetings with the former Secretary of Welfare, the present, and the Governor in pursuit of those.

Q. And what recommendations have you made over that period of time in those meetings with State officials?

A. Well, our concern, as you know, is to increase
]14-115] community services and we have made numbers of recommendations and, as I mentioned to you, the comments made by Dr. Hersh and Dr. Walker, I would like to inform the Court that every one of

those recommendations in regard to the system, and its ability to perform we have discussed with the previous secretary, the present secretary, and the Governor.

They have all agreed with us, yes, they are problems, they are things that can be corrected through administration changes. They have agreed and promised that they would do them.

However, to date, none of them have taken place.

Q. Will you compare by way of example some of those recommendations that you made to correct the situation?

A. The first one is that there is no one person in authority to implement what needs to be done.

We brought that right out to them and I can give you an example of the inability, the lack of authority.

Within the structure of the Department of Welfare is four regional deputy secretaries and the Eastern Regional Deputy Secretary is Dr. Hobbs.

Underneath him is the Commissioner of MR. The Commissioner of MR reports to the Regional Deputy Secretary.

However, in the office in Harrisburg, in a special office, also is the Deputy Secretary of the Office of Mental Retardation. That secretary is on the
[14-116] same level of the Regional Deputy Secretaries and the Deputy Secretary has no authority or ability to direct the Commisisoner of Mental Retardation.

If I am permitted to say at this time, previously, it has been indicated to us that the Deputy Secretary of the Office of Mental Retardation could develop programs and plans until he was blue in the face and he had no way of knowing whether they were implemented.

We have — PARC in 1974 completed their plan for the design for living for individuals.

One of the recommendations in that plan was that the Deputy Secretary of the Office of Mental Retardation have authority for programmatic planning. It was agreed upon by the present Deputy Secretary of Welfare, Helene Wohlgemuth — at that time his name was Frank Beal —

However, that has not happened and that causes delay.

Q. A further illustration of your recommendations, will you correct me on that?

A. Along with doubt in that area we also knew that the regional state does shape county plans. They form the policy, how programs will be run. They ultimately approve both the plans and the budget.

Usually the process is the county develops its plans and sends them to the region. There the re-

[14-117] gion approves those and upon their approval they go on to the central office and then the central office approves them.

Within both the region and the State they identify the priorities between the two of them. Priorities have been deinstitutionalization, the dispersal of people from such as Pennhurst.

Yet, when you look at the county plans, the county plans do not reflect the priorities and the policies and plans that have been established by the central office.

* * *

[14-118] Q. Is there any place in Pennsylvania where we will say the counties have made more progress than in this five-county area around Philadelphia; and when I say more progress I am talking about establishing beneficial community services for the retarded.

A. There are more services in some counties than there are in others but, generally speaking, I don't know if I would classify any of them as providing adequate services in any way in any one of the counties.

Q. Well, has more progress been made according to your observations in some parts of the state than in other parts?

A. Well, we have — in the western part of the region we do have — we have had movement of people out of our State institutions, where you see a larger development of community-living arrangements in the Western Region.

I believe, if my figures are correct, that the Western Region has the highest number of facilities for community living.

Q. When you say the Western Region, what specific area are you referring to?

A. The twenty-three counties beginning up at the top about Erie and going down to the bottom of the State, in the western part of the state.

Q. And has there been any substantial movement in the deinstitutionalization in that particular area and, if so, from what institutions?

[14-119] A. There has been considerable movement out of Polk, which was the largest institution in the western region. They have decreased their population from close to 3,000 down to 2,000.

Q. Polk is now approximately 2,000 as best you know?

A. That's right; 2,000.

THE COURT: All right.

I just wanted to get a basic idea.

BY MR. GILHOOL:

Q. Are there further recommendations that PARC has made to State officials with respect to shaping the performance at Pennhurst?

A. Right. The one recommendation has been made again and again, beginning in '68, '69, and so on; and that is the requirement for life-management plans.

And according to the new Deputy Secretary of MR, he has once more issued a memorandum that there shall be life-management plans for every resident; but at present they have not existed.

There are several other areas and one is the request for separate budget for accountability. We felt that the central office might have a better handle on what is happening in the area of mental retardation versus what is happening in mental health.

There is the category of funding along those lines also to identified funds.

[14-120] There has been no change. However, there has been agreement that that has been a good suggestion and me might implement it.

Q. What other recommendations has PARC made?

A. Well, the critical one in the course of making all of these recommendations, we ultimately faced the Deputy Secretary who was saying that the law of 1966 provides that if counties are not doing their job you have the right to step in and do it.

And we have requested that on many, many occasions where the counties have failed to move ahead.

We have made several other suggestions and we are very much aware that deinstitutionalization involves the economic question. There is the employment, according to my thinking, of about 22,000 people that will have to either lose their jobs or have to be reemployed in another way.

We have in the beginning requested for retraining, orientation to the tasks ahead. That is incorporated in a number of plans that we have submitted to the Department of Welfare that we felt this was critical.

We see that in many ways the staff and the institution are quite capable, know the people that they have to work with; and if they were moved over to new responsibilities in the community, that we might more effectively deal with the people coming back.

THE COURT: May I interrupt just once more
[14-121] and ask a question?

* * *

Q. You did, did you not, mention the figure of 22,000?
A. That's including all the institutions that we presently have in the Commonwealth.

* * *

[14-127] Q. Mrs. Schmidt, why is it over these many years of PARC's existence and in particular over the last ten years that you have testified to that PARC has sought community services to replace institutions?
A. After being in this room for over three weeks I don't know if I have to add any more to what has already been said.

When I listened to the testimony given by Robert Troester and Robert Hill and Herman Vaughn, I could hardly keep back the tears because that's where it is, that's why we want it.

We heard what it was like living in an institution and we heard what it was like living out.

Mrs. Auerbach, a seventy-seven-year-old mother, thank goodness she saw the day when her son was able to come back and acquire social skills.

That's what we want. Parents want the assurance. They need that; they need to know.

From the early beginning, when our organization first started, that desparate cry for help, co-

counseled each other. We came together, we looked for the day when we could be assured that tomorrow if we are not here somebody else is going to do it maybe even better than we did it.

That's what we need. We need to know that. That's why we think the community is the place. That's where all of us live, grow, develop, and die.

[14-128] It is the best integrated setting that I know. It can happen and we know it can happen. We have done it. We have demonstrated.

Our children were excluded from school and we have got now the most severe and profoundly-retarded children going to school every day. You pass the bus and you see them riding in the bus.

I have known children who stopped having epileptic seizures because they are interested in what is going by when they look out of the bus.

We have made great inroads. We have demonstrated with programs that we never believed that we could do.

We are now pushing for employment in many, many areas. We have achieved it, and it only happens in the community.

I think that's why we want community service, but we have got to have enough of the right kind in the right places at the right time.

* * *

Supreme Court, U. S.
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IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1980

Pennhurst State School and
Hospital, et al.,

Petitioners

v.

Terri Lee Halderman, et al.

Pennsylvania Association for
Retarded Citizens, et al.

and

United States of America,

Respondents

**ON WRITS OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT**

JOINT APPENDIX
VOLUME V, A813-A942

**Petitions for Certiorari Filed March 12 and 20, 1980.
Certiorari Granted June 9, 1980.**

THE LEGAL INTELLIGENCER, 66 NORTH JUNIPER STREET, PHILA., PA. 19107 (215) 561-4050

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**Qualifications of expert witnesses were stipulated pre-trial. Curriculum vitae designated as PARC and US Exhibits, detailing education, experience, publications and other qualifications of all plaintiffs' witnesses are found in the Final Pre-Trial Order filed at R. 464, March 31, 1978.

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Testimony of C. D. Youngberg

22-118] CLARENCE DUANE YOUNGBERG, having been duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. WATKINS:

Q. Where do you currently reside, Dr. Youngberg?

A. Beg pardon?

Q. Where do you currently reside?

A. 5055 Brown Drive, Spring City, Pennsylvania.

Q. And you are currently employed at Pennhurst Center?

A. Yes, I am.

Q. In what capacity?

A. I am superintendent at Pennhurst.

Q. How long have been so employed?

A. I was appointed superintendent in September of 1972.

MR. WATKINS: By the way, your Honor, there is a lengthy deposition of this witness that has been filed and we will only fill in the gaps.

THE COURT: Yes.

BY MR. WATKINS:

Q. Dr. Youngberg, could you give the Court a general overview of the institution from the perspective of its major divisions, administrative divisions, and living units?

A. Yes. I won't repeat that which has been presented already; I have been making note of it.

22-119] Of course, as we all know, Pennhurst has existed for many years, seventy years, and to bring us up to the present time, it reflects not only a different population but different needs, different services that need to be provided in contrast to many years ago when it was first created.

As we look at the people presently residing at Pennhurst and those who are being admitted or committed in recent months, it seems their needs

also are different from those who came to Pennhurst many years ago.

It seems that in recent months those coming to Pennhurst, their primary need is that of a residential place to live. This is not to say that there aren't other concerns or considerations of programming other aspects and special care needed. That enters in as well, but the primary reason is a place to live.

The task at Pennhurst then is to provide a living environment for the citizen where his basic needs can be met, as well as his other needs, however variable they may be, not only in terms of program needs, but special physical needs.

It is the purpose of Pennhurst to try to meet these needs as best we can with existing resources.

I think it is important to point out too that we start with the conception that for citizens residing at Pennhurst, this should be used as a temporary or interim place. In practice, that has not been the case.

[22-120] We also think or it has been spoken in terms of people living at Pennhurst, getting ready to return to the general community. Here again, in practice, it does seem to work this way, in that when we look at the community placements available, those citizens at Pennhurst who are higher functional, that present relatively fewer concomitant problems, are those more likely to leave; but viewing the overview of Pennhurst, we have to think in terms of the people living there.

It is not a matter of them getting ready to go somewhere else. It is a matter of the general community getting prepared to meet their needs so they can leave whenever this happens, whether it is a week, a month, or many years.

With this in mind then the structured organization that administers the structure in terms of this framework is that the major division of the facility is that of resident life.

* * *

22-128] Q. Now you testified at your deposition, and I believe reference was made to — I am reading an article, I am confused — that you really were shooting or that it was an acceptable goal for you anyway that Pennhurst be ended and people not have to go there some time.

Is that correct? Is that the thrust of your testimony?

A. No, not quite in that context.

I had said I would anticipate and hope for the day when the current need for Pennhurst would
22-129] cease and that people could be served in the community and would not need to come to Pennhurst; that the people living there might be adequately accommodated in the community setting.

* * *

2-149] BY MR. LASKI:

Q. Superintendent Youngberg, you testified on direct examination and I believe in your deposition that mental retardation in and of itself does not require institutionalization and there is a lack of resources in the community to meet the needs of people and that really it is not a matter of you preferring the people to go to the community; it is rather a question of the community preparing to receive the residents of Pennhurst.

Is that a correct statement?

A. That is correct; but that's somewhat taken out of context. There was more to it than that.

Q. Would you want to elaborate on it?

A. Well, as I said, it is not merely a matter of us making a person ready to leave Pennhurst, but we should also and can also take the terms of having the community ready to receive our people back.

[22-150] I had also noted that while people are at Pennhurst, to the extent that their functioning is raised, that their multiple behaviors are decreased or somehow minimized, that increases the probability that they will be able to return to the community because these are where the majority of the community-living opportunities exist for higher-functioning residents that present fewer problems than lower-functioning residents with multiple problems.

Q. Okay.

In that context, though, you did say in your deposition on page 102, I often say it is not a matter of our people getting ready to return; it is a matter of the community getting ready to take their people back?

A. That's correct.

Q. And does that statement apply to all persons at Pennhurst, severe and profound, as well as mild and moderate?

A. Theoretically, yes. Practically, there are problems with that; but theoretically that's correct.

Q. Practically there are some problems with the communities getting ready to take their people back?

A. Correct.

Q. In other words, it will require extra services, different accommodations than it would for other people?

A. At least that.

Q. Is that what you mean when you say practical problems?

[22-151] A. Right. It would take at least that.
Q. Are there any other practical problems that would put that statement in context?
A. It was mentioned earlier in different contexts. It is not only a matter of a place for people to live and all of that; it turns on the degree of supervision they would need and so forth and a program which they can or tend to participate in.

It also involves constructive and other activities for their other waking hours and then a monitoring system to make sure all of this is happening and continues to happen.
Q. And that has to be in the community for severe and profoundly-retarded people to live in the community?
A. Right. The problem is relevant to the community.
Q. We have had throughout the week some people who have testified, either explicitly or have implied, that some severe and profoundly-retarded persons who they knew in Pennhurst could not live in the community and they made distinctions between higher-functioning residents and lower-functioning residents.

Would you say it would be wrong to make that distinction, to say that profoundly-retarded persons, for example, cannot live in the community?
A. There is a great question. I would say it this way — I have found that severely-retarded persons can live in the community.

2-152] BY MR. SACKS:
Q. Repeat that.
A. I have found that profoundly-retarded persons can live in the community.

BY MR. LASKI:
Q. If some persons testified, for example, that there were profoundly-retarded people on Ward 6 at

Pennhurst who did not have the capacity to live in the community, you would disagree with that.

A. I am not certain in what context that statement was made or such statements were made, but it is not a matter of capacity *per se*.

It is a matter of their needs being met in the community or wherever they may reside.

Q. The context was a question. To somebody testifying here the question was or could be are these people who are profoundly-retarded persons — could they live in the community — and certain people answered no, they could not.

Would you agree with that or not agree with it?

A. I can't really agree with the statement because I don't know the context or the point of reference from which they are making that statement.

If they are talking in terms of living in the community with what resources or provisions presently exist, okay, that's one thing.

[22-153] If they are talking about a philosophy or theoretically, that's another thing.

Q. If they were talking in terms of the capacity of the individual —

MR. WATKINS: Your Honor, once again, I think the witness has answered.

THE COURT: Maybe you didn't hear his last answer, but I thought he did answer clearly.

BY THE COURT:

Q. I think you said it wasn't a matter of capacity, but it was a matter of whether or not services were available in the community.

Was that your answer?

A. That's correct.

THE COURT: To take care of them.

All right.

* * *

22-155] BY MR. LASKI:

Q. Even though it is not your view and it is not a true view that profoundly-retarded people do not have the capacity to live in the community, do you find it the commonly-held view by staff at Pennhurst or people who are working in the field in community programs?

A. I don't know that it would be a commonly-held view.

There are people coming from various points of reference, at various points in time.

I think that would be also true of myself. At one point in my life I may have felt that way and at other times not.

I don't know that it would be a commonly-held view. I know there are at least some persons who don't hold the same view as mine and are hesitant about lower-functioning residents being able to live in the community.

But I think it is not so much a matter of that; it is just the overwhelming concern as to whether their needs would be met in the community, and I

22-156] think people are responding to that.

In my comments on the theoretical basis and philosophical basis, I said yes, they can, and should live in the community.

Our difficulty is accomplishing this. I am not attempting to suggest it is impossible.

* * *

2-162] BY MR. LASKI:

Q. Superintendent Youngberg, in your position you participate in a number of planning efforts for institutional reform, deinstitutionalization and depopulation of Pennhurst?

A. Yes, in a variety of planning efforts.

Q. There have been a number of plans developed over the years, have there not?

Q. There have been various plans as well. I think it would be more accurate to say a number of planning efforts, which may or may not have developed into formal plans as such.
Q. In other words, there may have been plans and documents written?
A. Yes.
Q. But they have not come to fruition?
A. (There was no response.)
Q. You heard Mr. Foster testify about the deinstitutionalization and institutional reform plan?
A. Yes.
Q. Basically his testimony was that the deinstitutionalization part did not work too well.
[22-163] A. That was not carried forward.
Q. And is that your experience? You wrote a part of that plan, did you not?
A. No, I did not.
Q. You were superintendent when it was written?
A. Yes, I was.
Q. If it turns out that the officials in Harrisburg, either alone or with your participation, developed another plan to depopulate Pennhurst or to deinstitutionalize residents from Pennhurst and provide services in the community for people from Pennhurst, is there anything changed now that would lead you to believe that that plan might be implemented more readily than plans in the past have been?
A. To be implemented more readily?
Q. Right.
A. I would have no specific reason to believe that, other than in recent weeks and months there seemingly is more consensus that institutions reach into federal office levels as far as service.
Q. The barriers are an obstacle to providing services and the community has not obviously made plans to provide these services; is that correct?

A. Well, that's a difficult question in that the planning that has taken place has been effected in some instances and not yet accomplished in others.

[22-164] Now in that respect, whether that is effective to the plan, I couldn't really say.

Q. Have you been participating in the last few months in any new plans to provide services in the community for the people at Pennhurst?

A. I don't know as there would be any new plans, just a refinement of planning that has gone on for a number of years.

Q. During discovery I recall that the overall plan for meeting Medicaid standards involved reducing the Pennhurst population to 1,000, 1,004 people. That figure stands out in my mind.

Has that been revised? Is that a current plan or is there some new thinking along those lines?

A. I recall during that planning activity we recognized as a result of the life safety code that our rated capacity would be diminished, but then also projecting that the 1977 MA rate would also have implications for us, such as the maximum four beds per room, so we looked at our facility in terms of what that might mean, and that's what came out to a population of 1,004.

So we looked to what changes in resources or modifications would be required to meet that and that's the standard plan.

Now beyond that we were looking to see if there are ways to further reduce population and there is nothing firmed up particularly to my knowledge.

22-165] Q. Have you had discussions about further ways to do that?

A. Oh, yes, discussion for months and months and months.

Q. And who are the primary discussants?

* * *

[22-166] Is that your question, what they are planning now?

MR. LASKI: That's exactly the question and if you want to answer that open-ended, that's what I am interested in.

We have very detailed information, Dr. Youngberg, from your deposition, from Mr. Foster's deposition, and from other depositions.

THE COURT: You are talking about the last couple of months?

MR. LASKI: I want to know what has been happening in April, in the last few weeks, in terms of your plan to provide services in the community for the people at Pennhurst and who has been working on it and what your thinking is.

THE WITNESS: Well, as I noted earlier, it is just a continuation of prior planning, looking for ways to bring ourselves into compliance with Medical Assistance, and an endless process, whether additional resources are needed, whether they can be modified, or whether it is possible to further reduce the population at Pennhurst, not that that is a goal, but to place the citizens in the community, which would result in population reduction.

This would have other implications as far as meeting Medical Assistance.

We had hoped we could get down to a thousand
[22-167] and hope to go beyond that.

The people that are ordinarily involved in this process, certain of the staff, the regional officials, and I would defer to Mr. Rice and his staff and Daniels is involved in the DGS process.

Resident living, nothing new. This has been handled for several years.

At the central office level the Deputy Secretary for Mental Retardation, Mr. Polloni, and his staff, would necessarily be involved in planning, just like Mr. Meyers, his predecessor, was involved in the planning.

BY MR. LASKI:

Q. Your characterization is that there is ongoing planning refinement of your philosophy and plans to carry out basically the intent for community living that the Department and Pennhurst have had for the last five or six years?

A. Well, at least that, consistent with our desire for institutional reform for those that remain at Pennhurst for as long as they remain at Pennhurst, and also those that are able to leave, and what that involves in terms of getting ready resources in the community.

THE COURT: Let me ask a question, if I may.

BY THE COURT:

Q. Do I understand you to be saying that the present overall plan is to reduce the population at Pennhurst to about a thousand?

22-168] A. Well, we hope to go beyond that. First, it was 1250, then a thousand, and it will get lower and lower and eventually four or five hundred or beyond that if we can.

We have looked at figures of 1250, we have looked at figures of 1,000, we have looked at figures of 850, and we have looked at figures below that.

Q. But you consider that all of this is consistent to state that you are presently planning on facilities that will take care of a thousand and also to state that you hope to go considerably beyond that?

A. That's correct; yes.

Q. Do you think that is consistent —

A. Yes.

Q. — planning?

A. Yes. The reason we can't be too specific as far as the future is because much of this depends on resources or budgeting available.

We can talk fairly firmly in terms of existing and what exists now in terms of this fiscal year and carryover.

Q. I am sure you heard the testimony of the plaintiffs and I won't ask you whether you believe it or not, but you heard the testimony of plaintiffs that these services could be provided at a lower cost in the community. Now I want you just to assume for the purpose of this question that this is so, that they could be provided at a lower cost in the community.

[22-169] Then wouldn't the objection to having a larger budget to accommodate this sort of pass by and not be a hurdle to accomplishing, we will say, the depopulation of Pennhurst?

A. I understand there has been testimony that it would be — that it would cost less. I don't know whether that is, in fact, true.

That's a point that I have not yet been convinced of, but that should not be the motivating factor.

Q. Suppose it costs exactly the same. Let's assume for the purpose of my question that it is going to cost exactly the same, whether you take care of the mentally retarded out at Pennhurst or take care of them in the community.

Then do we not eliminate the question of budget and finances in planning for moving the residents of Pennhurst into the community?

A. There would need to be an adjustment in funding mechanisms and the community programs for the most part. At present they are funded through the county and there needs to be a mechanism for providing adequate funding through the county.

Q. What you are saying is that there has to be a mechanism for the State to funnel that money into the counties if you were going to use that amount of budget at Pennhurst, we will say, to help the counties function with their community facilities.

Is that what you are saying, in effect?

[22-170] A. Yes.

Q. Well, we heard testimony here, Doctor, that there are, under Act 256, certain funds provided.

Did you hear that testimony?

A. Not all of that, but I am aware of that.

Q. Are you aware of the fact?

A. Yes.

Q. That at some place in this great Commonwealth there is something like $18 million sitting there waiting to be used for community facilities, or a figure up in that area?

A. I think it is important, though, to recall that this is capital money to acquire and construct facilities and it doesn't really pertain to operational funding; and it was operational funds to which I was referring.

Q. Do you think it would be any different in legislative reaction to a request for $26 million to take care of the retarded residents at Pennhurst if the requests were to come from the counties in connection with the same 1200 retarded individuals?

A. I think it would probably depend on how strongly their constituents express their opinions.

The Legislature would be responsive to others. I don't know.

Q. Let's assume that the people that have testified in this case so far, and that includes, I think, the witnesses produced by plaintiffs and yourself here —

22-171] I think you have expressed a professional opinion, or I should say to be fair with you, that it is theoretically better to provide these services in the community than it is in an institutional setting.

Didn't you say something like that?

A. I was saying it is theoretically possible to do it.

Q. I thought maybe I misunderstood you and I don't want to put any words in your mouth. I thought you were saying it would be better to pro-

vide services such as this in a community setting rather than in an institutional setting.

Did you say that? I don't want to put words in your mouth.

A. I don't know whether I said it exactly that way.

I think it is best for people to be served in a setting most like the normal setting or the mainstream of Society.

This can be done well if the needs can be met, if they are not jeopardized in any way, not suggesting that they would be, but that would be assurance we would want.

Q. As a professional, do you think it would be to the advantage and the benefit of the retarded population of this Commonwealth to be serviced in a community setting or serviced in an institutional setting?

A. Basically, I'd have to say yes, I think it would be —

Q. Yes to community or yes to institution?

[22-172] A. Pardon me, yes to the community, in that I think it is more important to first of all serve people, if possible, in a community setting rather than having a larger residential facility.

I am not willing to say at this time that all people presently living at Pennhurst should be living in the community. That's a very individual decision.

Q. Do I understand your reservation in connection with all people has been based on your observation that there are not community facilities available to take care of all the people in Pennhurst?

A. Not only all, not necessarily all people in terms of numbers, but all people in terms of needs.

Q. Yes.

A. And in addition to that, there are persons at Pennhurst who are certainly resistive to moving from Pennhurst, as we all tend to be resistive to change.

Q. Have you ever had any experience other than at Pennhurst with a relative that was old and didn't want to move out of the old house when the roof was falling in?
A. Certainly.
Q. And where those in the family that were interested had to go and practically carry them to a new and a better location?
A. Yes.
Q. I am just sort of paraphrasing the situation.
A. I am familiar with the situation.
[22-173] Q. In the long run wasn't that move to the advantage of the old person that had been in the old home where the roof was falling in?

Wasn't it better that they be in a safer facility, a healthier environment?
A. Generally so, but it depends. I know persons who have died —
Q. Died because they were moved?
A. No, because of the trauma, because of very resistive people.

There are people who are resistive to a new location.
Q. You know somebody that died because they were moved?
A. Yes, just talking about the trauma of the situation; and I don't wish to imply that that would be true of Pennhurst, but the point I try to make is that it is a very individual and a very personal decision.

I think it is one we want to encourage, to counsel, to have persons who are capable of making decisions and families who are resisting to look at all options available, most certainly those available in the community.
Q. This old person that died, was that a resident of Pennhurst?
A. No, it was not. It was just one of several examples that I recall.

THE COURT: Yes. All right.
I interrupted.
Do you have any further questions?

* * *

[22-184] BY MR. LASKI:

Q. Is there anything in your experience as superintendent in dealing with the budget, in dealing with the appropriations, with the allocations, with the contracts, that would make it impossible to deploy money allocated to Pennhurst to provide services for people in the community, former Pennhurst resi-
[22-185] dents in the community?

A. If there is some reason why this could not be done I am not aware of it. I just don't recall any.

Q. And, in fact, —

A. I don't know of any.

* * *

[22-219] BY MR. PEABODY:

Q. Dr. Youngberg, do I understand correctly from your earlier testimony that the process of deinstitutionalization to be a proper one in your view would be done on an individualized basis so that each individual resident is looked at and placed in a place for that individual's best interests?

[22-220] A. That is true.

Deposition of Clarence Duane Youngberg

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

TERRI LEE HALDERMAN, et al.,
Plaintiff,
UNITED STATES OF AMERICA,
Plaintiff-Intervenor,

v.

PENNHURST STATE SCHOOL AND HOSPITAL, et al.
Defendants.
CIVIL ACTION
NO. 74-1345

Oral deposition of CLARENCE DUANE YOUNGBERG

* * *

[102] DR. YOUNGBERG:

As to the future, we would like to anticipate the day when Pennhurst would not need to exist, that the needs of all citizens with retarded behavior could be met within the community setting. As I said a number of times, it is not mental retardation per se that requires the institution. It is just the lack of alternate resources, whatever they may be in the community, to truly meet the needs of people, including those with retarded behavior.

I often say that it is not a matter of our people getting ready to return. It is a matter of the community getting ready to take their people back. While
[103] they are here, it is certainly our responsibility to do whatever we can to raise their level of functioning, recognizing that opportunities as they do exist tend to be for possible or probable higher functioning residents with fewer accompanying problems. So to that extent, as residents do increase in level function and their behavior level increases, their probability of community return is greater, not because

it should be that way, but that is where opportunities presently exist to a greater degree.

BY MR. THRASHER:

Q. Would you judge that some residents at Pennhurst while they have been here have regressed in their life skill abilities?

A. I don't know that as a fact. We have discussed this from time to time. At least, I have discussed it with other people from time to time. But a person is not able to cite examples where this has occurred. I recognize the possibility exists that it might have.

Q. Are there some conditions here which are consistent in your professional judgment with an expectation that it might occur for some residents?

A. I think such conditions have existed and still exist to some degree.

Q. At Pennhurst?

A. Yes.

Q. Did you finish your statement? I interjected. I
[104] am sorry.

A. Essentially so. That is essentially my statement.

MR. THRASHER: I yield the witness.

BY MR. LASKI:

Q. Dr. Youngberg, do you recall the March 1975 visit of Dr. Jim Clements to Pennhurst?

A. I recall he was here, yes.

Q. Were you the Superintendent at the time of that visit?

A. Yes, I was.

Q. Do you recall preparing any documents in anticipation of the visit of Dr. Clements?

A. I recall preparing documents. I am not sure whether it was for Dr. Clements.

Q. I show you an untitled document which has 32 item entries in it, and ask you whether you prepared that or whether that was prepared under your supervision in March of 1975?

[105] A. Yes. I recall this is the document, yes.
Q. Did you prepare this document?
A. I was involved in the preparation of the final review of the document, yes.
Q. I ask you to turn your attention to Page 4 of the document, Item 32, which is entitled "Recommendations for Improvement Resources by Priority."
A. Yes.
Q. Would you read what is the first priority that is entered under that topic?
A. Yes.
Q. Would you read it for the record, please?
A. "Adequate number of each type of community living arrangements with appropriate 'backup' services to both (a) terminate the need for future commitments to Pennhurst, and (b) provide option to each Pennhurst resident of leaving the institution if he or she so desires."
Q. Does that reflect your judgment of the top priority for Pennhurst residents in March of 1975?
A. To the best of my recollection, yes.
Q. Would you still say that statement or that general premise of adequate number of community living arrangements is still a top priority of residents at Pennhurst today?
A. If you would continue with the phrase "with ap-
[106] propriate backup services," yes.
Q. Is it your judgment that it is a top priority to terminate future commitments to Pennhurst?
A. I would currently perceive it in this fashion, that if the needs of any prospective admission to Pennhurst, if the needs could be met adequately in the community, there would be no need for him to even seek admission to Pennhurst.
Q. Dr. Youngberg, there are three other recommendations for improvements under that topic. Would you please just characterize each of those recommendations? You may read the first sentence

or characterize it. There is no need to read each one. Would you either read or characterize the second recommendation?

A. I would like to read at least the first sentence.

> "2. A safer environment in which each and every Pennhurst citizen would sleep and carry on the activities of his or her waking hours."
>
> This makes reference to the Life Safety Code Project, or in lieu of or until such, at least, the people be relocated to other facilities. That is essentially the heart of it.

Q. Is that still a valid recommendation for improvement today?

[107] A. It is still valid, but to a lesser degree in the context that the Life Safety Code Project is under way. That would reduce the degree of risk or relative unsafety that existed two years ago.

Q. Is it a correct reading of No. 2 that at the time you wrote this you projected the completion of the Life Safety Project within two years, which would be March 1977?

A. That is what it says. So that would be accurate.

Q. That projection was not accurate though, was it?

A. It proved not to be accurate.

Q. If you were making the same projection in terms of completion of the Life Safety Code Project, what would your projection be?

A. I wouldn't be able to project a date.

Q. Would you either again read the first sentence or characterize Recommendation No. 3.

A. "3. Increase complement of 'direct resident contact' staff to adequately meet the needs of each and every citizen residing at Pennhurst."

Q. Is that a valid recommendation for today for residents of Pennhurst?

A. It is still valid in that No. 3, though I made reference to sets of standards with which others are familiar in terms of whether it is valid today, I would still make reference to the standards.

[108] We also base our impressions or projections on needs identified as a result of the multi disciplinary process or policy or the team policies at Pennhurst.

Q. Is it a correct reading that Recommendation No. 3 reflects that you had at that time made budget request proposals to implement that recommendation?

A. Yes, I made such requests in our budget proposal.

Q. To what extent were those requests fulfilled?

A. This was in?

Q. March 1975.

A. It is my recollection that our staffing complement at that point was 1,580. It is presently 1,562. It has been less than 1,562, but it is presently 1,562.

Q. So you had more staff at the time you made this recommendation than you have today?

A. I could check a document.

I guess I don't have it. I am quite certain it was 1,580 at that time.

Q. Recommendation for Improvement No. 4, what does that say and what is the essence of that recommendation?

A. No. 4 was, "Humanely designed and furnished environments in which each and every Pennhurst citizen may live, grow and develop until community facilities and resources are adequate to enable his or her return. Traditional institution environmental

[109] constraints, 'the normalization principle' until community living arrangements exist in sufficient quantity and quality to truly provide an alternative to institutional for all, the environment for traditional institutional structures and operations must be innovatively designed and constructed along

with 'community settings' and consistent with the normalization principle."

Q. I take from your testimony that that recommendation is still valid today?

A. Essentially so, recognizing that there have been improvements in environment and actual living areas exist and are available for the people now that didn't exist at that time. A case in point would be the modular units.

Q. I direct your attention to Page 3 of this document, Item 24, which is entitled "Number of Residents That Should be Discharged."

Would you read your response to that item.

A. It says "Theoretically, all residents could be discharged, given adequate community living arrangements with appropriate back-up services. The question of whether they should becomes an individual decision."

Q. Could you explain for me the meaning of the opening word "Theoretically, all residents could be discharged"?

[110] A. Well, what is intended by that is that given appropriate community-based living arrangements and services, not only in terms of program but activities a person presently living in Pennhurst could also be living in the community. Theoretically, I guess there was some question as to at what point in time this may occur.

Secondly, I made the qualification that if a person does leave Pennhurst, I feel that should be his or her decision, if he is capable of making that decision. The question does arise that if a person has lived at Pennhurst for many years and perhaps has even tried a variety of community placements which have been unsuccessful for one or more reasons, he feels very strongly about living out his or her life at Pennhurst. It becomes a very individual decision. I certainly think counseling is appropriate.

But to say, "You shall move," I would not willingly say that at this point.

Q. In other words, your qualification goes to not impose that on an individual when his choice is to live in a certain environment rather than in another?

A. His choice must be considered. It certainly must be considered.

* * *

[124] Q. Dr. Youngberg, do you recall an article in the Philadelphia Magazine in December 1976 by Loretta Schwartz, which was entitled "The Forgotten Children, Pennsylvania Condemns its Most Helpless Kids to a Living Death"?

A. I am not sure — yes, I recall the article. I think I read it a couple of times.

Q. It is an article about Pennhurst Center.

A. Yes. As best I can fathom from it, yes.

Q. Did you have an opportunity to speak with the author, Miss Schwartz, prior to the publication of that article?

A. Yes, by telephone.

Q. By telephone?

A. Yes.

Q. One time or more than one time?

A. It was, as I recall, one time prior to the article. She had tried apparently to either stop by or to tele-

[125] phone me internally, and I was not able to get back to her until relatively a short period of time before the article went to press.

Q. So you talked to her over the phone?

A. Yes.

Q. And did not meet her personally at all?

A. Not prior to that time. I met her subsequent to that. Subsequent to that there was a photographer at Pennhurst. I believe she was with the photogra-

pher. I am not sure whether I met her then or at a subsequent occasion, but I have seen her in person.
Q. I am going to show you a copy of the Philadelphia Magazine of December 1976, page 225. Would you read the paragraph beginning, "I don't think there should be a Pennhurst."
A. "I don't think there should be a Pennhurst. ('I don't think there should be a Pennhurst,' says Superintendent C. Duane Youngberg. 'In a large residential facility, good care is an almost impossible task.')"
Q. Did you make that statement?
A. No, not in that context nor in that format.
Q. Did you make a statement similar to that?
A. Not with that implied meaning. As best I can recall, there was a fairly lengthy conversation. I think
[126] I was anticipating some future time when the needs of retarded citizens would be met in community settings and there would no longer be a need for Pennhurst and State centers such as this. As best I recall, it was in that context.
Q. So consistent with your previous testimony today, given the development of adequate community alternatives, that statement would be an accurate reflection of your comments to Loretta Schwartz?
A. Well, to say I don't think there should be a Pennhurst is not really accurate because that doesn't imply it and of itself, you know, the alternative.

See, it is one thing to say there shouldn't be a Pennhurst and then look for other alternatives, if they even exist, in contrast to saying perhaps someday there will not be a need for Pennhurst. Today there is a need for Pennhurst.
Q. So a correct interpretation of that statement would be, given the development of adequate services in the community for residents of Pennhurst, there need not be a Pennhurst, is that correct?

A. That is close. That is not my recollection of the conversation with her. It was in relation to future projections and needs of persons being met in the community. It wasn't what you would call Pennhurst specifically, but it was Pennhurst representa-
[127] tive of larger facilities such as this and then ceasing to exist because the need for them has ceased to exist. It was in that context.

Q. What about the part of the quotation, "Any large residential facility, good care is almost an impossible task"?

A. I don't recall saying that.

Q. Do you agree with it or disagree with it?

A. I don't think it is an almost impossible task. Relatively, the larger any agency, the difficult it is in terms of management, simply because of the span between top management and the direct receivers of care.

Q. In your experience and in your readings and your discussions with your colleagues, do you know of any institution the size of Pennhurst which is held up in professional circles to be giving good residential care?

A. Not personally. Dr. Clements, I think he referred to his facility as meeting that criteria or one at least in that general geographical area.

Q. He has a facility of 1,200.

A. He made reference to a facility of comparable size. I am not sure if it was phrased quite that way or if it was phrased in State compliance with JCAH standards. It may have been in that context. But the implication is that these needs were being met, at
[128] least to a greater extent than at other similar facilities.

Q. You don't recall exactly the facility that he was referring to?

A. No, but it was a facility of comparable size because I asked him.

Q. It wouldn't have been a facility of about 400 or 500 people, would it?
A. No. It was at least 1,200.
Q. In which state?
A. It was either North or South Carolina. If he gave me the name — I don't know that he gave me the name. I didn't know personally of that facility myself.
Q. So the answer to my question is—
A. I personally do not.
Q. You personally do not know of a facility?
A. No, I personally do not.
Q. In which good residential care is being provided?
A. No, "good residential care" as defined how?
Q. As defined by professionally acceptable standards, not in terms of JCAH standards or Medical Assistance standards, but in terms of common knowledge to the profession.
A. I don't know of any from personal experience, good in that context.
Q. Would you read again from the Philadelphia
[129] Magazine, Page 225, the following three paragraphs ending with, "I myself would go elsewhere and help."
A. "I came to Pennhurst filled with the hope that I could improve the lot of these people." That is a Schwartz term, "lot."
Q. We can talk about it after.
A. "I came to Pennhurst filled with the hope that I could improve the lot of these people. In Oregon, while I was working on my doctorate, one of our projects was to train the severely and profoundly retarded to work in industry, and there was a very low error rate among those we taught to do complex assembly work. Some actually earned more money than the doctors who trained them.

"When I first arrived at Pennhurst, the residents were being forced to move into the recently completed New Horizons Building. When I saw these wards, my flesh just crawled. I was ill when I left the building."

Do you want me to continue, or do you want to start to discuss it first?

Q. Continue.

A. "Many, theoretically all, of these people should be living in the community. If this place were closed down and people had a better place to go, I'd be de-

[130] lighted. I myself would go elsewhere and help.

" 'In fact,' Youngberg added with a slight tremor in his voice, 'sometimes I ask myself why am I here?' "

Q. Apart from the characterization of whether or not you had a tremor in your voice, did the paragraphs you read reflect substantially an accurate version of your discussion with Loretta Schwartz?

A. It was not an accurate reporting of my comments.

Q. Is it inaccurate in regard to the summarization of your work in Oregon?

A. It is not accurate.

Q. In what respect is it not accurate?

A. The first part where she said I came to Pennhurst filled with the hope I could improve the lot of the people. To my recollection, I was recalling the circumstances under which I came to Pennhurst, and that was through my past association with Wes White, who was the then Superintendent of Pennhurst. It was Wes White who introduced me to Special Education at the Rainier School in the State of Washington. I thought with his leadership and I could learn from him and share with him my experiences at Oregon, Wisconsin and Rainier subsequent to his leaving, and that together we would be able to do something at Pennhurst.

[131] With respect to my recollection of training severely and profoundly to work in industry in Oregon, this was true, with low error rate. That was significant. There were two, to my recollection, that earned more money than the doctoral students — not doctors, but doctoral students who trained them.

Continuing on, when I first arrived at Pennhurst, the residents were being forced to move into their recently completed New Horizons Building, which was the hyperactive patient building at that time.

"When I saw those words, my flesh just crawled. I was ill when I left the building." I don't recall that terminology at all, although I do remember Wes White, the then Superintendent, taking me through the building, which was not yet completed, and he and I expressed similar concern that they were still constructing facilities such as this with large living areas of the hospital type design.

There may have been further uncomplimentary remarks at that time, but I don't recall saying that my flesh crawled and that I was ill. I was probably upset, you know, that they were still building such buildings.

Going on, "Many, theoretically all, of these people should be living in the community." The state-
[132] ment by itself is accurate, but it was really just part of the whole conversation.

Q. That is essentially the same statement we read previously?

A. Putting it back in context.

"If this place were closed down and people had a better place to go, I would be delighted." I can't recall my phrasing anything of that nature. But again, it was in relation to someday perhaps all people, their needs will be met in the community and there would be no further need for Pennhurst.

Q. Would you be delighted if that happened?
A. I anticipate the day favorably that the need for Pennhurst will no longer exist. There is a need today. I hope today that in the future there will no longer be a need.

"Sometimes I ask myself why am I here." I know why I am here.

Q. Did you speak to Loretta Schwartz about that article after it was published?
A. No.
Q. Did you ever complain to her that you were misquoted.?
A. No, I did not.
Q. Did you ever complain to anybody in Philadelphia Magazine that you were misquoted?
[133] A. No, I did not, because I — well, okay, I did not.

MR. LASKI: I have no further questions.

* * *

MR. LASKI: Yes, I have a few questions.

[22-77] BY MR. LASKI:

Q. Mr. Foster, in your deposition you went through basically all the programs that you supervised and evaluated some of the program services at Pennhurst.

Is it a fair conclusion that at the deposition you stated that Pennhurst was not a normalizing environment?

A. That's right.

Q. Is your testimony today consistent with that deposition, that given available services in the community no one need be at Pennhurst?

A. That's right also.

Q. And your testimony is that there are a lot of practical problems in making that become a reality?

A. That's right.

Q. Is 't your practice and responsibility or is it Mr. Matthews' responsibility to review restraint and seclusion and accident reports?

A. Mr. Metzger?

Q. And you do not ordinarily review those in the course of the year?

A. No, I do not.

Q. And you reviewed especially the reports which

[22-78] you commented on in direct.

Did you review these especially at the request of your attorney?

A. I was asked if I knew anything about those particular instances, those particular cases, which i did.

Q. They had come to your attention previously?
A. Yes, they had.
Q. You just testified that — I forget the exact year, but the Pennhurst staff undertook a great deal of effort on a deinstitutionalization and institutional reform plan?
A. That's right.
Q. Again, what was the period of that plan?
A. That was approximately 1974, the end of 1974 — the beginning of 1975.
Q. And you testified that the institutional reform component related basically to the unit system and you did not comment on the deinstitutionalization, but I believe you said that fell short.

What were the components of that plan? What was the intent of that plan and what happened to that part of the plan?
A. The intent of the plan was to have a set of meetings on an ongoing basis between members of the institution, members of the five-county ARC's, and attempt to get the county administrators and BSU people involved, and just a whole host of community agencies in the Southeast Region to get together to deal with, first of all, some overall questions with respect to the problems with deinstitutionalization and also to attempt to initiate some programs or some proposals, at any rate, at which certain things could be done, even given the restriction of funding, the dual funding stream and all of those things.

[22-79]

That was the intent. In addition, —
Q. Excuse me.

Was the rationale behind that if you were going to get deinstitutionalization you would have to have the people in the community, the people in the BSUs, and the people in the counties as well as Pennhurst working?

A. That's correct.
Q. In other words, you could accomplish pretty much the institutional reform aspect as an internal staff operation, but to accomplish the deinstitutionalization you would have to bring together and coordinate the various agencies?
A. Yes.
Q. And what was the result of those plans?
A. There was a lot of meetings. Unfortunately, there was nothing as substantial as was done with the internal business on the lattices and exit and entry criteria.

We did — we were able to formalize some very small things in terms of attempts that had been going underway to get something started, and I am
[22-80] thinking in particular of a program in Pottstown which was run by the Montgomery County Association for Retarded Citizens, the backslider, and it was through this forum or this body that some of the plans, at least, were developed toward accomplishing that.

In addition to those regional meetings, I believe that it was every month — there may have been a few months which were missed, but there was a State — what they called a State Deinstitutionalization Reform Committee which later changed its name to The Mental Retardation Forum, which met in Harrisburg or Camp Hill, again to discuss some things — issues on a state-wide basis.
Q. Were people from the State Office of Mental Retardation in those meetings?
A. On occasions there was representation by someone from the Office of Mental Retardation, yes.
Q. Do you know if the Deputy Secretary of Welfare or the Secretary of Welfare knew about the progress or non-progress of the deinstitutionalization plan?
A. She was given reports on this, yes.

Q. Was there any response from the Secretary of Welfare or from any of his establishment as to how to correct the lack of progress that was being made on the deinstitutionalization phase?
A. Not to my knowledge.

* * *

[23-5] **Testimony of P. G. Samuels**

* * *

BY MR. WATKINS:

Q. Where do you currently reside, Miss Samuels?

A. Philadelphia.

Q. Are you currently employed?

A. Yes, I am, by the Commonwealth of Pennsylvania.

Q. In what capacity?

A. Director of Institutional and Program Support for the Southeastern Regional Office.

Q. What does the Southeastern Region encompass?

A. The five counties — Philadelphia, Chester, Bucks, Montgomery, and Delaware.

Q. How long have you held that position?

A. Five years with the Southeast Region; one year prior to that out of Harrisburg.

Q. Would you describe what your responsibilities are in that capacity?

A. Yes. I monitor the three institutions,twenty-one private licensed facilities, various support services, and have responsibility for coordinating the Act 256 or DGS projects.

MR. WATKINS: Excuse me one moment, your Honor.

BY MR. WATKINS:

Q. What does that DGS stand for?

[23-6] A. The Department of General Services. It previously was the General State Authority.

Q. In that capacity have you had occasion to become familiar with what has been referred to in this courtroom as Act 256 and the implementation or lack of implementation of Act 256?

A. Yes, I have, since January of 1973.

Q. And would you briefly tell the Court what Act 256 is and what its history has been in the department?
A. Yes. It is an act of the Legislature which previously was Senate Bill 1304, Printer's Number 1914, which was enacted. It was a capital budget bill.

A part thereof was for the Department of Public Welfare, Section 21. Section 21 covered the $21 million in question for the purpose of planning, design, and construction of mental-retardation service units, including the acquisition of property and construction or renovation of said property.
Q. Now were there any time limits in this act?
A. In reading it —
Q. Why don't you read the section of the Act that deals with the $21 million that you referred to?
A. All right. I am reading from Senate Bill 1304, Printer's Number 1914, starting on page twenty-nine, Section 21.

> For planning, design, and construction mental-retardation service units and acquisition of property, total population surveys, and
> [23-7] total system analysis as required to provide a definitive treatment and normalizing accommodations for mentally-retarded residents of Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties, and to be located in the same counties. The units are to provide accommodations for approximately 900 patients to reduce the population at Pennhurst State School and Hospital to a maximum of 1,000, this capital investment to provide logical dispersal and reorientation into the community for Pennhurst residents and alternatives to institutionalization for the Pennhurst waiting-list population and other mentally-retarded citizens of the

area who require such treatment and accommodations. This program is to be completed as expeditiously as possible so that the first units may be occupied not later than two years from the effective date of this act. (Base construction costs, acquisition, survey, and analysis, $16,863,000).

On the right-hand side appears $21,079,000.

Q. What is the difference?

A. The difference is roughly twenty-three percent of the construction cost, base construction cost, which is to cover the DGS.

Q. The Department of General Services?

A. Department of General Services administrative costs, including the architect's fees.

[23-8] Q. Is it that the projects themselves are to be developed and constructed by the Department of General Services?

A. Yes, they are.

Q. Let me back up a little bit now.

You came on board when? In what year?

A. I took on this project in January of 1973.

Q. Have you had occasion to become familiar with what occurred prior to January of 1973 with respect to Act 256?

A. In terms of the documents that were supplied to me by Harrisburg and other documents that I might have read at, say, other Commonwealth offices.

Q. As far as you can determine, what was done to implement this act between November 1970 and the time you came on board with the department?

A. The bill was signed on November 27th of 1970. In March of 1973, Scope, which is an official document — the number on the document appears as GSA 362-8-63—

It is a legal document, Scope, which is supplied to the General State Authority outlining the expenditure of any of these funds.

Q. Who submitted it to the department?
A. The Department of Welfare submitted it to the General State authority.
Q. When was that done?
A. It was approved by the General State Authority
[23-9] in March of 1971, is the date that I have.

MR. GILHOOL: Your Honor, I rise exactly to that point. The year of her testimony was 1973, her earlier testimony.

THE WITNESS: I am sorry, '71. A Scope was submitted at that point in the amount of $68,000 to conduct the planning phase, Phase I, it was referred to as.

That is oftentimes referred to as the McDowell report.
Q. All right.

What happened in Phase I?
A. There was an orientation meeting in April of '71, a preliminary meeting at the end of April of '71. The orientation meeting was the beginning of April and then a pre-funding meeting in July of '71 and a final meeting in the end of September of '71.

That report was then accepted.
Q. Let me ask you, you described these as preliminary meetings and pre-final meting and so forth.

Are these terms that commonly are used?
A. Yes. They are terms within the legal contract with the Department of General Services with a provider, a contractee.
Q. Are these required meetings?
A. Yes, they are. They are established at the orientation meetings, the time plan.
[23-10] Q. Did the McDowell report ever come to be?
A. Yes, it did.
Q. Do you know when?
A. It was approved in November of 1971, pending some minor changes which the Department re-

quested be made at the September 30, '71 final meeting.

Q. Have you had occasion to examine the McDowell report?

A. Yes, I have.

Q. And could you describe to the Court what it is?

A. It is a philosophical statement and then a population survey of the residents in the community, I believe also on the waiting list and at Pennhurst.

It then lists the number of programs, community-living arrangements, and day programs and support services that were seen as being needed to service the roughly 600-plus Pennhurst residents which were identified.

Q. Now you said that there was a population survey.

What did you mean by that?

A. I am not familiar with exactly what they did, but from reading the report it appears that they did analyze all of the residents at Pennhurst and came up with somewhere slightly in excess of 900 residents that could be dispersed or served through the sixteen - seventeen million dollars.

Q. Do you know how that analysis was conducted?

A. No, I do not.

[23-11] Q. What types of information did it contain, the population survey?

A. All that is in the report states that X number of residents in Bucks County, as an example, would need a Type 1 group home or a Type 3 group home, et cetera.

* * *

[23-52] [CROSS-EXAMINATION OF P. G. SAMUELS]

[BY MR. GILHOOL:]

Q. You testified as to what your recollection was of the Phase I McDowell report which provides a

blueprint for the planning and expenditure of Act 256.

Am I correct that your recollection was that Dr. McDowell and his staff did not collect data on the Pennhurst residents in terms of determining what types of residential programs they would need?

A. No. I said he did collect data. He must have in order to have made the recommendation that Bucks County needs X number of this type of facility.

I believe what I said was I did not know exactly how he went about collecting data.

Q. From your reading of the report you don't remember whether he explains his data collection?

A. I don't remember that. I haven't read the report.

Q. Have you read the report recently?

A. No, I have not.

Q. Do you recall whether the Pennhurst staff actually participated in the data collection about the residents there?

A. I would assume that they did, yes.

Q. Do you recall a chart or a figure in the McDowell report which indicated the characteristics that were tabulated by Pennhurst staff in terms of developmental level, current status, motor skills, eating skills, dressing skills, ambulation and toilet training?

23-53] A. No, I do not.

Q. You also testified, I believe, that your recollection of the McDowell report was that it planned for residences and programs to serve 900 plus?

A. I believe that was the figure, yes, 954-something.

Q. 959?

A. It could have been, yes. I don't know the exact figure.

THE COURT: I didn't quite hear your question.

What is the question that 950-some would be the answer to?

MR. LASKI: The witness testified on direct that her recollection of the McDowell report was that it had planned for 959 residents of Pennhurst; that it had planned programs and services and residences for those people.

And my next question is —

BY MR. LASKI:

Q. Do you recollect whether Dr. McDowell and his staff also planned for residences and programs for the 2,199 residents who were at that time on the waiting list for residential placement at Pennhurst?

A. I do not know specifically, but I would assume that they did since in the wording it includes the individuals in the waiting list.

Q. You don't recall a Table 7 in the McDowell report which was entitled "RETARDED ON THE WAITING LIST WHO NEED A SMALL LIVING
[23-54] UNIT IN THE COMMUNITY", which breaks down by county and living arrangements those people on the waiting list?

A. No, I do not.

Q. Do you recall from your reading of the report whether, in addition to the people on the waiting list and the 959 designated in Act 256, Dr. McDowell and his staff actually submitted plans for the other residents of Pennhurst who need small living arrangements in the community and in —

A. No, I do not.

Q. Dr. McDowell's report then — do you know whether Dr. McDowell's report had contemplated replacements in the planning of residential facilities for approximately 4,800 people as opposed to just 959?

A. No, I do not.

Q. Do you recall in what detail Dr. McDowell planned for the types of community-based residential facilities that were needed and the details by which he sited them in each county?
A. There were charts, as I recollect, that said X number — in each type of home or facility and the number of individuals for each.

And then it was totaled, therefore, we need X number of this type.
Q. And did the types include life support, infant nursery, child development, pre-vocational, habit-training, behavior, and habilitation-training type and crisis-assistance type?
23-55] A. Yes, if these are the nine types of group homes, yes.
Q. And each one of these types was designed and sited by county and by number of residents that would need that type of facility?
A. I believe each of those nine types were listed on the chart.

I do not remember if each county needed so much of each type.
Q. Did not the McDowell report county by county indicate the proposed facilities that were necessary for each county?
A. Yes. As I said, I think there was a chart for each county.
Q. Did you think the McDowell report provided a blueprint for placement in the community of those 959 residents designated in Act 256, the other residents of Pennhurst, and the people on the waiting list?
A. Yes, it did when it was accepted.
Q. You indicated in your direct testimony that one of the first things that happened in terms of implementation of Act 256 was that two years after the passage of that act group homes were removed from the project plan; is that correct?

A. No. One of the first things was the McDowell report was commissioned.

Q. One of the first things in terms of implementation of the McDowell report was that group homes were scrapped from the plan; is that correct?

A. That is the first thing that I found in going
[23-56] through some back records.

Q. And you testified that from going to back records you learned that Commissioner Goldman made that decision?

A. Yes.

BY THE COURT:

Q. Would you explain to the Court what you mean by the interpretation of his decision that group homes were excluded?

A. The nine types of CLAs, the community-living arrangements; but eight of the types, with the exception of the Type 1 or life-support units, were removed so that we were not going to spend any of the $17 million to acquire and renovate or construct small residential living units with the exception of the Type 1 because there was another funding for us available to provide those homes.

Q. I recall you did so testify, but you didn't tell us, what is that other funding?

A. It is the CLA. I don't know what it appears as in the county budget, but it is the community-living arrangements or the group-home program.

Q. Financed by the State Government or the Federal Government?

A. The State Government, I believe.

BY MR. LASKI:

Q. Do you know by what authority Commissioner Goldman made that decision?

A. I believe because this was a program for MR
[23-57] service units and he was the head of the MR programs in Philadelphia at that point. Therefore, he

said this is how we wish to spend the money that was appropriated to us.

Q. In other words, the Department of Public Welfare is making the decision in terms of how to spend the Act 256 money?

A. Yes, because it is my understanding that the money was part of the Welfare Department appropriation for the purpose of providing MR service units.

Q. The other funding source that you told the Judge about, was that designated specifically for 900 or 959 residents at Pennhurst?

A. Do you mean the CLA funding?

Q. Yes.

A. I don't know whom it was designated for originally.

Q. Was it designated for any residents of Pennhurst, specifically, as Act 256 is designated for residents at Pennhurst?

A. I don't know.

Q. Your testimony was after that decision the McDowell report essentially became inoperative and the planning process had to start again?

A. Yes. There are aspects of the McDowell report that we were able to salvage and use, mainly, the rough cost estimates, space allocations.

There are certain pages in it, as I remember, that say X per foot, X dollars, that type of thing; the descriptions of the programs.

23-58] Q. But at that point the planning shifted from previous State planning by the commissioner to planning by counsel?

A. I believe that was also planning and work between the McDowell report and November of '72, when the group homes were removed; but there was work by the counties. The counties had begun to do some site selection, et cetera, for programs to

implement the McDowell report arrangements and all of that ceased when the group homes were removed in November and then it had to begin again.
Q. The planning then went to the county level and each county presented and submitted plans?
A. Yes, I would say that's true following the November of '72 decision.
Q. And in accordance with your testimony those plans were submitted to the regional office?
A. Yes.
Q. And by that time, April of '73, you were at the regional office to receive those plans?
A. Yes, I was.
Q. Were they all approved at the regional office?
A. Yes, and I believe they were only approved as submitted.
Q. And then you transmitted them to the people in Harrisburg?
A. Yes.
Q. And were they then all approved there?
A. Yes, I believe they were. There were changes on
[23-59] the part of counties at later dates, at which time they requested that their original plans be revised, and that was done.
Q. And was it Commissioner Goldman at that time who made the decision to approve the five county plans for getting the GSA program moving again?
A. I do not remember who was commissioner or deputy secretary at that time.
Q. Somewhere from the Department of Public Welfare?
A. Someone there, yes.
Q. And once those program decisions were made and plans set in place, it was sent to the General Services Administration to do the ministerial task they always do to get construction?
A. Once the Department of Public Welfare ap-

proved the Scope, prepared and approved the Scopes, they were sent to them the General State Authority.

Q. That would have been in April of 1973; right?

A. I am not sure when the first set of Scopes were submitted.

Q. The language of Act 256 itself says nothing about fifty percent here or fifty percent there or fifty percent Pennhurst or fifty percent community, does it?

A. No, it does not.

THE COURT: I read it.

BY MR. LASKI:

Q. Do you know when that policy originated? Was it at the same time you changed policy on the group
3-60] homes that you changed policy on the numbers?

A. I believe that I have been saying that and implying that to the counties as a guideline probably since at least 19 — at some point in '74, '75. It may have been before. I am not sure when.

Q. It is clear that it isn't a guideline in communications from you and Dr. Rice to the regional office. You made that clear to the county in the last couple of years.

My question is where did that originate. Did it originate in your office or was that discussed with the Secretary of Public Welfare and people in Harrisburg?

A. I believe it originated in our office. It was discussed with Harrisburg.

Q. Was it your testimony that in about September of 1974 you were engaged in site selection and actually considered the location of some of the projects?

A. I believe that's roughly when we completed it.

I do not know that at some point between — well, during the period between February of 1974 and November of '74 that the eleven sites which

had to be acquired were acquired, that all acquisition was completed by November of '74.

Q. Now during this period of 1973 - 1974 were you preparing regular reports to the Secretary of Public Welfare or the Commissioner of Mental Retardation on the progress of Act 256?

A. I was preparing reports for the Regional Com-
[23-61] missioner and I believe some of them were sent to Harrisburg then. To whom, I am not sure.

* * *

[23-63] BY MR. LASKI:

* * *

Q. I show you PARC Exhibit 60, which is a report entitled DGS 523 Report from Russell Rice to Aldo Colautti. It is actually from Russell Rice and Pamela Samuels to Vincent Pettinelli and it is the same exhibit that Mr. Gilhool handed the Judge previously.

Did you prepare this report?

A. Yes, I did.

Q. And you prepared it on July 28, 1976?

A. If that is the date of it, yes.

Q. What was the occasion for you preparing this report in 1976?

A. I believe we were requested by either the Secretary or Mr. Colautti to provide a status report as of that time.

* * *

[23-77] BY MR. LASKI:

Q. To move along, have any of the projected bid dates in your memo to Mr. Colautti been met?

A. I think, if I remember, that one — the Pleasant Manor one. It looks like we were estimating that that would be met.

23-78] The Lower Merion was not met in January, though it was bid in May of this year, so that was close, if close counts.

And that would be all. I think then it sounds like one is anticipated still to be met and one to approach being met.

Q. Did you have an overall projection for the entire completion of the DGS project when you wrote this to Mr. Colautti?

A. It does not appear there but I think I did.

Q. Would it have been April 1, 1979?

A. It might have been, yes.

Q. And the projected date you gave to Mr. Watkins on direct was by 1980?

A. Yes, January of 1980, I believe.

Q. So on July 26, 1976 you were projecting an April 1, 1979 date and in May of 1977 you are projecting a July 1980 date?

A. No. It was January 1980.

Q. A January 1980 date?

A. (There was no response.)

Q. So in the last nine months we are basically in the same place we were nine months ago, when you wrote this memorandum, in terms of the anticipated time we are going to have to wait for the completion of the DGS projects?

A. For the completion of the last one or all of them, yes.

Q. So there has been essentially no progress made?

23-79] A. I don't know, we have got three out to bid and we have got Philadelphia's design started and moving.

That's nine out of seventeen. That's better than fifty percent.

Q. Just one further question.

When you assumed your position or in consequence, did you have occasion to read the report by the Bolton Associates of the MRI program for the

Pennsylvania Association for the Mentally Retarded?

A. I don't believe I read is in depth, no.

Q. I'd just like to read one sentence to you and ask you if you agree. The Bolton Associates said of the mental-retardation system that it lacks accountability, responsibility is diffuse, authority is non-existent or confused. Delays and confusion surround the mandated dispersion of nine hundred Pennhurst State School residents is an example of tragic proportions.

Would you agree with that?

A. Would you read it again, please?

Q. Sure.

The system lacks accountability, the responsibility is diffuse, authority non-existent or confused. The delays and confusion surrounding the mandated dispersal of nine hundred Pennhurst State School and Hospital residents is an example of tragic proportions.

THE COURT: What is the date of that report?

[23-80] MR. LASKI: 1973, April 1, 1973.

THE WITNESS: I would say when it was written that that probably was true, yes.

BY MR. LASKI:

Q. Is it true today?

A. No.

Q. How many people, how many Pennhurst residents are now living in DGS-built facilities?

A. None, because none of the DGS-built facilities have been built.

Q. How many Pennhurst residents have been dispersed since 1956?

A. What is your definition of Pennhurst residents?

Q. As defined in Act 256?

A. Presently residing at Pennhurst and dispersed as of a given date?

Q. Pennhurst residents who were living at Pennhurst when Act 256 was enacted.
A. According to the programs that were operational as of April 2 25th, it appears that thirty-seven Pennhurst or ex-Pennhurst residents were being served in our Embreeville residence with a projection that by June 30th there would be thirty-nine Pennhurst residents plus four Embreeville residents, with a possibility of an additional two from Pennhurst.
Q. That's next June? That's going to come up by June?
A. By June 30th, the thirty-nine plus four.

Testimony of R. G. Rice, Jr.

* * *

[26-34] BY MR. GILHOOL:

Q. Mr. Rice, does any resident at Pennhurst have to receive services there because of his handicap?

A. Would you explain further?

Q. Does the handicap of any of the 1200-some residents of Pennhurst require that services be delivered to him in that restrictive, that segregated a setting?

A. No.

Q. Everyone at Pennhurst, therefore, could, so far as his or her handicap is concerned, receive services

[26-35] in a less restrictive, more integrated community setting?

A. If there was an appropriate residential arrangement in the community, appropriate day-program services, and support services and ongoing relationship with the responsible county, that is correct.

Q. And the absence of those services is the only thing that keeps anyone at Pennhurst at present?

A. Obviously, that has to be the guide.

Q. Of course, all of the things that are necessary for the presence of the residents?

A. That's correct.

Q. You testified yesterday it would be inhumane, I think, to disperse the residents of Pennhurst tomorrow.

Would it be inhumane to disperse them a year from now?

A. What numbers are you describing?

Q. There are presently 1200 residents at Pennhurst.

A. To disperse the total number of people within a one-year period?

Q. That is correct.

A. That would be inappropriate. As I described, the act, the Mental Health-Mental Retardation Act, is basically a county-based system. The counties are responsible for after-care services as I described and the counties have identified a number which I have
26-36] described that translates into 370 individuals as their maximum capacity to properly serve those individuals.

Q. Okay.

So that the inhumane part that you made reference to is not a matter of timing and effect, but a matter of the production of the community services that are necessary to sustain the residents in the community?

A. That's correct.

MR. GILHOOL: May I approach the witness, your Honor?

THE COURT: You may.

BY MR. GILHOOL:

Q. I show you PARC Exhibit 63, which is "Community Living Arrangement Program Analysis and Program Plan for Fiscal Year 1977-78," and, in particular, an unmarked page thereof towards the back of the document.

Do you recognize that document?

A. Yes.

Q. All right.

Now the page to which I direct your attention has a title called "Definitions of Community Living Arrangement Types;" is that correct?

A. Correct.

Q. And it defines there eight types of community-living arrangements?

A. Correct.

26-37] Q. And the first type is the developmental maximation unit; is that correct?

A. Correct.

Q. And that type is meant to serve what sort of handicapped persons?
A. Defined as an educational residential program for the medically complex, multiply-handicapped persons.
Q. Do you know how many such people requiring developmental maximation units presently reside at Pennhurst?
A. I don't know off the top of my head but I can have access to it.
Q. Please take the time and use the access.
A. Approximately fifty-nine.
Q. Fifty-nine?

* * *

[26-45] [BY MR. GILHOOL:]
Q. Now you testified about half an hour ago that this was — do I have your language correct? — the first acceptable plan for deinstitutionalization at Pennhurst put together by the State, the region, and the county?
A. I believe so.

MR. GILHOOL: I am uncertain, your Honor and counsel, whether a copy of this plan has been presented to the Court.

MR. WATKINS: No, it hasn't and I will be glad to do so now.

Your Honor, we have specifically discussed this occurrence when we were drawing up the pre-trial order. In my pre-trial order I don't show this as listed.

MR. GILHOOL: I have no objection.

MR. WATKINS: Does anybody object?

MR. PEABODY: No.

MR. WATKINS: We shall provide counsel with copies.

(Commonwealth Defendants' Exhibit CD-727 was marked for identification.)

BY MR. GILHOOL:

Q. Now putting aside for the moment Mr. Cotton's
[26-46] demurrer and Montgomery County's demurrer, you testified, did you not, that this plan is your plan and the counties'?

A. A joint planning effort.

Q. A joint planning effort, whose product has—

Now wait a minute. It was planned jointly, but this product has the assent of your office and of the counties?

A. I have documents from the counties confirming that, yes.

Q. All right.

Is this plan also the plan of Deputy Secretary Hobbs?

A. Correct.

Q. And is it the plan of the Deputy Secretary of Mental Retardation Services Malone?

A. Correct.

Q. And the plan of Deputy Secretary Aldo Colautti?

A. Correct.

Q. And of Secretary Beal?

A. Correct.

Q. And of Duane Youngberg?

A. Correct.

Q. And is the plan, in other words, of the State Department of Public Welfare?

A. Correct.

Q. And of the counties?

[26-47] A. Correct.

Q. It represents, does it, the best judgment of what you can do in the next year and a month?

A. That we can do?

Q. Yes.

A. Yes.

Q. And it represents your best judgment of what you can do in that time, formulated after seven weeks of trial, after two years of litigating; is that correct?

A. It is the plan for '77-'78 for the dispersal of the individuals at Pennhurst Center as described, regardless of where they are in point of time.

Q. It is the judgment of the Department and of the counties of what can be done in the next year and one month, or longer, as you indicated, when the money was available?

A. When the money comes into the present funding stream in the present system that we are working under; that is correct.

Q. Okay.

Now let's look at the particulars of the plan, if we may.

Do you have a copy in front of you?

A. Yes.

Q. At page one the first item there, among the 169, is a special CLA funding, sixteen out of the sixty-eight already dispersed?

A. Right.

[26-48] Q. And fifty-two to be dispersed?

A. Right.

Q. Is that the unspent community arrangements money from fiscal '75-'76?

A. Mr. Bilyew described at one time the funding process as related to that sixty-eight individuals. That is only part of the total CLA dollars.

Q. Well, these dollars represent a part of the unspent funds in fiscal year '75-'76; is that not correct?

A. These were additional dollars given to the Southeast Region above its original appropriation for CLA.

Q. I appreciate that but my question, however, is where do these dollars originate?

Do they originate as unspent dollars in the fiscal year '75-'76?
A. Unspent '75-'76?
Q. Yes. Sometimes you call them carryover dollars, don't you?
A. These are —
Q. Are you aware that during fiscal '75-'76 the five counties in the Southeastern Region failed to spend certain dollars for community-living arrangements and for other community services?
A. These funds came from, at that time, family resource services.
Q. That is to say—
[26-49] A. It was carryover money from the FRS program, when it was in Appropriation 57.
Q. All right.

Family resource services appropriations for the fiscal year '75-'76, which were allocated to the counties but not spent by them, were carried over and in December of 1976 transmuted into the fund for the CLAs; is that correct?
A. Right. It was in the same appropriation at that time.
Q. Okay.
A. None of these moneys, by the way, came from the unspent funds in the Southeast Region.
Q. They came from unspent funds elsewhere in the State?
A. That's correct.
A. Aha, aha.

Now this money was put out last December; is that correct?
A. I believe so, yes.
Q. And it was put out for community-living arrangements for occupancy within sixty to ninety days; is that correct?
A. Yes.

Q. And in your deposition of March 14th, at page 160, you testified that within this fiscal year, meaning the current fiscal year, those sixty-eight residents at Pennhurst will be dispersed into community-living arrangements; is that correct?
A. That's correct.
[26-50] Q. Now we have got one month to go in the fiscal year.

Will the sixty-eight be living in the community and receiving services there by June 30th?
A. I cannot guarantee it, but it will be shortly afterwards.

Obviously, the identification of the defined areas, the outside date is December 31st.
Q. The outside date for the sixteen —
A. Totally.
Q. 1 through 5 is December 31st?
A. Obviously, some of the dispersal will take place prior to that.
Q. All right.

And what is your expectation with respect to the sixty-eight? When is that going to take place?

On March 14th it was by June 30th. On this date what is it?
A. I don't have the complete count in front of me.
Q. Item Number 2 is contracted foster care.
A. Correct.
Q. And that calls for ten residents at Pennhurst to move into foster care in the community?
A. Correct.
Q. On March 14th you testified, did you not, at page 171 of your deposition, that before the end of the fiscal year ten to fifteen then Pennhurst resi-
[26-51] dents would be in foster care; is that correct?
A. If that's what it says.
Q. Now will ten to fifteen residents at Pennhurst be in foster care by June 30th?

MR. STUTMAN: Page 171.

THE WITNESS: The answer to the question is that those individuals will be in foster-care placements prior to December 31st.

MR. GILHOOL: All right.

BY MR. GILHOOL:

Q. They will not be by June 30th?

A. I cannot guarantee that they will be there by June 30th, but they will be before December 31st.

Q. Okay. All right.

A. Now on March 14th you thought that it might be as many as fifteen who would be in foster care by the end of this fiscal year.

Why does it say ten here rather than fifteen?

A. The ten is a conservative number. There is the possibility, the likelihood, that it could be in excess of ten.

Q. So that these are conservative numbers?

A. That is a conservative number.

Q. I thought you testified about forty-five minutes ago that these numbers are bounded at the outside by your judgment of the capacity of the mental-re-

[26-52] tardation system, State and county, to actually deliver?

A. That's correct.

Q. But it is not correct for this foster-care number?

A. We identified two areas, one which is current funding and one which was new.

The combination of those equals 370 individuals.

Q. How many of the 201 are you intending for foster care, have you planned for foster care?

Have you identified both the appropriate program and made the judgment that those resources can be created in the period of time indicated?

A. I believe the counties have identified four individuals.

Q. Yes. Okay.

Now with respect to the ones on Line 3, that is, community-living arrangements vacancies, you showed twenty people filling those vacancies.

Do you expect that by the end of June or again are we somewhere in the period between now and December 31st?

A. As identified, no later than December 31st.

Q. All right.

Now you were in the courtroom when Mr. Bilyew testified?

A. Yes.

Q. Did you hear him testify or did I hear correctly that as of the middle of April or was it at the end of
[26-53] April there were seventeen true vacancies in the community-living arrangements program for Southeastern Pennsylvania?

A. No, I did not hear that.

Q. Do you have a recollection of what number of true vacancies he spoke of?

A. I believe the true vacancies, if I can recollect, was ten, I believe. It wasn't that number?

Q. It was less than seventeen; all right.

Now did you also hear Mr. Bilyew testify that for those true vacancies as of the end of April there were already referrals and I understood him to mean multiple referrals for all of them?

A. Right.

Q. Now he didn't testify that any of those referrals were from Pennhurst, did he?

A. I don't recall having heard his testimony.

Q. He did, however, testify that apart from the true vacancies of ten or seventeen there were theoretical vacancies, that is, there were 120 CLA slots which had been authorized and funded some time ago, about two years ago, which programs have not yet become operational; is that correct?

A. The point is that in his discussion with the county these twenty individuals could be served in the CLA vacancies.

Q. My question at the moment is not about those twenty individuals, but rather do you recall that Mr.

26-54] Bilyew testified that there were 120 CLA slots authorized and funded for some few years in the five-county area that had not yet opened?

A. No, I don't recall that.

Q. You don't recall.

Of your own knowledge are there approximately 125 CLA slots funded and authorized over the last few years but not yet opened?

A. No, not — that's not true.

Q. How many are there?

A. I don't know, but I know it is not of that magnitude.

Q. What magnitude is it?

A. I don't have those details. There is an individual on my staff who would have those details. I do not have those details.

Q. Well, suppose it is of the order of magnitude of twenty or fifty or a hundred, you say it is not 120.

Is it more than 120?

A. It would be less than 120 and based upon his assessment twenty additional individuals could be served.

Q. You are back to the CLA vacancies?

A. Yes.

Q. Twenty could be served in additional vacancies?

A. Correct.

Q. With a current true vacancy of ten or seventeen and with some undefined number.

Do you know when you asked him the question

26-55] how many people can you put into CLA vacancies?

A. I asked him to look into the present status and how many he projected in conjunction with the counties.

Q. And the report to you is the sole basis for the presentation here of that number of twenty?
A. With stipulation with the counties, yes, that is a distinct possibility.
Q. Okay.

Did you ask him, when he said twenty for vacancies, whether he meant twenty vacancies or whether he meant authorized funded but not opened programs that might open in the next year and a month?
A. That would?
Q. That might.

Did you ask him that would?
A. That would, as I understood it in the beginning.
Q. All right.

And that applies only in this CLA vacancies of twenty?
A. True, true.
Q. Okay.

Now 4 and 5 — seventy-two transfers to Embreeville and fifteen transfers to Woodhaven Center or to other centers.
A. That's right.

[26-57] BY MR. GILHOOL:
Q. Let's try the statewide basis for a moment.

I recall you testified a little while ago that you got funds unspent in other parts of the state for these sixty-eight.
A. That was a different appropriation.
Q. I understand. You said that was a family resource service appropriation.

Have you, since March 14th of this year, received a statement of the unspent state allocation funds in the five-county Metropolitan Philadelphia area?
A. Have I received it for '75-'76?
[26-58] Q. '75-'76, the fiscal year that ended last June.

A. The last county submitted that on January 27th.
Q. On January 27th?
A. Yes, but I don't have access — I don't have that particular figure.

That's when the report was submitted.
Q. So that you did have those figures by March 14th?
A. I did not personally have those figures, no. I do not know when that goes —
Q. When did they become available to you?
A. I don't have them as of yet.
Q. Then I can't ask you and you can't answer what order of magnitude these are.

Those figures were not taken into account in the formulation then of this plan for the next year and a month; is that correct?
A. When those counties have identified, once they give each year's expenditure report confirmed, and based upon the appropriation that the Legislature appropriates, there are X amount of dollars to go to the counties.

That would be a combination of new dollars as well as dollars that were carryovers from the previous year.
Q. Of course. I understand that as a general matter.

My question is whether the carryover funds from the last fiscal year were taken into account in
[26-59] the preparation of this plan.

You have told me that as of this date you don't know what those funds are.

How is it fair to say that for —

Are you the author of this plan? Are you the idea man who put a lot of thought into this?
A. There were many individuals involved.
Q. All right.

Now were those funds taken into account in the formulation of this plan for the next year and a month or more?

A. The reflective process has assimilated, so I will say yes.
Q. And how many dollars were they that were taken into account?
A. As I said before, I don't have that specific figure.
Q. You then took them into account. If your answer if yes, it was taken into account here, please tell me who put them into the account.
A. Not specifically for the particular plan.
Q. Aha! Then it was not —
A. These moneys were coming from the State.
Q. I beg your pardon?
A. These moneys have been placed in the county programs throughout the state. I cannot earmark at this point in time what that particular thing means in terms of each county's program.
[26-60] Q. Did any of the five counties get any of those funds?
A. I don't know if they have or they have not.
Q. How did they distribute those funds if you didn't know how much was left over, if you couldn't tell the State how much to distribute?
A. That would be up to the regional secretaries and —
Q. I see. Those —
A. I don't see those figures.
Q. Those figures don't go to the Commissioner of Mental Retardation in the five-county area whose duties you testified were responsibility to present a plan to the five counties to make those figures go? Those figures don't go to the Commissioner; is that what your testimony is?
A. That's correct.

[26-61] * * *

BY MR. GILHOOL:
Q. Mr. Rice. Exhibit 56 shows 342 people transferred between the date January 1, 1972 and May

31, 1976 from Pennhurst State School and Hospital to Embreeville State School and Hospital.

Is that correct?

A. Correct, correct.

Q. Now your proposal is, in the next year and one month, to transfer an additional seventy-two from Pennhurst to Embreeville; is that correct?

A. That's correct.

Q. And with those seventy-two more Pennhurst residents Embreeville will then be an institution of 414; is that correct?

A. (There was no response.)

Q. Now that's mentally-retarded residents; is that correct?

A. No, I don't believe it will be over four hundred, no. I believe it is closer to 385 but I don't have the specific figures in front of me.

Q. You don't have the specific figures in front of you?

A. No.

Q. Is there anything there you might find the figures in?

26-62] A. I believe the present Embreeville Mental-Retardation Census is somewhere between 300 and 313 individuals.

Q. So that the site of Embreeville then will be somewhere between 372 and 385?

A. That's correct.

Q. All right.

Do you know how many mentally-ill residents there are at Embreeville State School and Hospital?

A. Today? No, I don't.

Q. Do you know the order of magnitude?

A. (There was no response.)

Q. Is it 300? Is it 200? Is it 400?

A. I don't have that figure in mind.

Q. Do you have any idea of what ball park it is in?

A. Prior to the transfer to Norristown —

Q. Oh, there were transfers from Embreeville of mentally-ill patients to Norristown?
A. Excuse me, to Haverford.
Q. To Haverford?
A. Correct.
Q. And indeed it is the case that those transfers —
A. Those transfers have taken place. I don't know what the present mental health —
Q. Over the last several years; is that right, transfer of mentally-ill patients from Embreeville to Haver-
[26-63] ford State Hospital have taken place over the course of the last three or four years, have they not?
A. Well, this has happened fairly recently when they phased out the mental-health unit at Embreeville.
Q. And that took place because both Embreeville and Haverford were under-utilized; is that correct?
A. That's correct.
Q. And because the mentally-ill patients or persons who have been moved from Embreeville to Haverford, mentally-retarded patients have been moved from Pennhurst to Embreeville; is that correct?
A. Yes.
Q. Now you testified earlier that none of the 1200 residents at Pennhurst required, because of their handicap, services in an institution of the size and segregation of Pennhurst.

Do any of the 414 require, because of their handicap, an institution of the size and segregation of Embreeville?
A. They don't require it.

* * *

[26-78] [BY MR. GILHOOL:]
Q. Now this move of seventy-two Pennhurst residents to Embreeville had been contemplated for quite a long time; is that correct?

A. That's right.
Q. When was it first considered?
A. Back in the late 1960s, I believe.
Q. I am sorry, I don't mean that reference of 342 who have already gone.
[26-79] I am talking about the additional seventy-two whom you propose be moved from Pennhurst to Ebreeville in the next year and one month.

When was the move of this seventy-two first proposed?
A. My recollection is that it was part of the original thinking back in the late 1960s, when the transfers began.
Q. You understand that the transfers to Embreeville generally were part of the original thinking in the late sixties?
A. Surely.
Q. Or early seventies?
A. Yes.
Q. But my specific question is when did consideration of transferring another seventy-two from Pennhurst to Embreeville originate?
A. In my recollection it was not an additional seventy-two. My recollection is that it was part of a larger figure that was identified, I would imagine, by DPW.
Q. Back at the beginning?
A. Back at the beginning.
Q. I see.

Do you know what that larger figure was?
A. No, I don't.
Q. Do you know what that larger figure would be, that is, the mere fact that this is the last seventy-two
[26-80] that the region, state, and counties in their original plan are going to recommend be transferred to Embreeville?
A. If the moneys are appropriated as I defined and we get down to the figure of 850 for Pennhurst.

Q. And then they will be gone, the 200, through July of 1983, if all of that happens?
A. I said as far as getting down to that 850 figure, then there would be no need to tranfer additional individuals to Embreeville.
Q. Now there have been nine transfers to Embreeville since you have been Commissioner of Mental Retardation; is that correct?
A. I believe that's correct.
Q. Why haven't the seventy-two, since the thought long ago was to transfer this additional seventy-two, including this seventy-two — how come these seventy-two are being proposed for transfer next year instead of over the last few years?

Why hasn't it happened before?
A. Because the building that they would be residing in — one particular building — is not presently certified under the Medical Assistance program.

It is projected that it will be certified, meeting Medical Assistance care standards.
A. So this proposal of moving seventy-two to Embreeville in the next year and a month depends
[20-81] upon the certification of another building to meet Medicaid standards, which has not yet been certified?
A. No, but they are —
Q. When do you expect it to be certified?
A. The moves, the transfers from Pennhurst will take place prior to December 31st. That has been the first phase of the life safety code renovation.
Q. So that your projection on this compliance with the life safety code as distinguished, for example, from Pennhurst's compliance about which you testified at some length in direct, your projection is that that certification is going to be in hand before December 31st?
A. Correct, and that —

Q. And that thereupon you will move the seventy-two people?
A. Correct.
Q. Is that the only reason why these seventy-two people have not been moved to Embreeville heretofore?
A. Prior to their moving they will have to be moved into a certified building with appropriate numbers of staff to meet the minimal Medical Assistance standards.
Q. Do you know how much money is being spent to refurbish this building to meet the life safety code and then the higher standards of Title 19?
A. For that particular building? No.
I have a figure for the total life safety code.

26-82] Q. At Embreeville?
A. Yes.
Q. Okay.
What is that figure?
A. $1,800,000, I believe.
Q. $1,800,000?
A. That's correct.
Q. For Embreeville, as compared with $1,800,000 for Pennhurst?
A. Correct.

26-84] * * *

Q. Okay.
Now I should like to show to you PARC Exhibit Number 25, which is a series of letters dated in the spring of 1972, this one from Edward R. Goldman to the Commissioner of Mental Retardation, the then Commissioner of Mental Retardation of the Commonwealth of Pennsylvania, to William D. Beach, Jr., the Secretary for Mental Health and Mental Retardation, entitled "Proposed Expenditure of All Capital Funds for Pennhurst," and I should like to

read to you or have you read, as you prefer, a particular paragraph and ask you whether —

A. Why don't you read?

Q. Okay.

Commissioner Goldman describes the Embreeville transfer operation as, of course, a compromise.

It would be foolish to consider this stopgap phasing of Pennhurst residents into two-year-old hospital buildings designed to provide custodial care for mental patients as anything but a temporary measure forced upon us by the emergency of an obsolete, deteriorated, and overcrowded state school and hospital system. To do so would violate Office of Mental Retardation principles and policies to the
[26-85] same degree that Pennsylvania's existing mental-retardation institutions violate these principles and policies. However, it is a compromise that could be acceptable and one the Department might implement without losing credibility if it is made clearly subject to the constraints implicit in the Office of Mental Retardation principles and policies and with a guaranteed time limit placed on the continuing use of Embreeville consonant with a rigorous departmental enforcement of county program responsibilities to develop and establish adequate and appropriate residential and non-residential community alternatives to institutionalization for mentally-retarded persons and their families.

Does that say satisfactorily to you what you would say about the Embreeville transfers?

A. I don't quite understand your question. It says —

THE COURT: Whatever it says, it says beautifully.

THE WITNESS: Now what was the question?

BY MR. GILHOOL:

Q. Under your proposal are the transfers of the seventy-two to Embreeville to be time-limited?

A. It is seen as a transitional facility, not any facility of permanency, a facility of compromise.
Q. Okay.
A. It is seen as a transitional facility.
Q. Has the transition happened for the 342 who
[26-86] were transferred from Pennhurst to Embreeville between 1972 and 1974?
A. There have been some transfers out of Embreeville but not to the degree that was stated in that paragraph that you read.
Q. You testified a half an hour ago that there have been fewer moves from Embreeville to community-living arrangements?
A. Right.
Q. Than from Pennhurst to community-living arrangements, and that's under thirty or, as you said the 180 figure, of forty or forty-five.
A. There have been less at Embreeville; correct.
Q. Now among the 342 people who went to Embreeville some time ago, are the 200 for whom you propose community-living arrangements in the next year and a month or more?
A. I don't think so, no, but I don't know the individual names.

26-102] * * *

BY MR. GILHOOL:
Q. I show you POPULATION RESIDING AT PENNHURST, a report of the Pennhurst State School and Hospital dated October 31, 1976, and direct your attention in particular to that part of the chart which designates county of residence, and then a total number of residents, a total of persons who originate in that county, and it says division by 121.

So that in your plan for the community residential services for forty-seven people in Bucks County,

that compares, is it correct, with fifty-three Pennhurst residents originating in Bucks County?
A. As of that date?
Q. As of October 31, 1976.
A. Correct.
Q. And in Chester your plan for nineteen compares with sixty-four Pennhurst residents originating in Chester County; is that correct?
A. Correct.
Q. And as to Delaware County, your plan of twenty-seven compares with 132 Pennhurst residents originating in Delaware County?
[26-103] A. Right.
Q. And as to Montgomery County, your sixty compares with 124 Pennhurst residents originating in Montgomery County?
A. Correct.
Q. And as to Philadelphia, your forty-eight compares with 491 originating in Philadelphia County?
A. Correct.
Q. And that's without reassigning the 400 Pennhurst residents who, an average of twenty-five years ago, originated in other counties or even out of the State; is that right?
A. That's just the Southeast Region.
Q. Exactly.

That chart, however, shows an additional 400 residents completing the population of Pennhurst as of that date who originated elsewhere; is that correct?
A. Correct.

* * *

[27-3] PROCEEDINGS

(Resumed in Courtroom 10B at 2:17 o'clock P.M.)

* * *

CROSS EXAMINATION (resumed)

BY MR. GILHOOL:

Q. Mr. Rice, let us return to our discussion of what you called the first acceptable plan for the
[27-4] deinstitutionalization of Pennhurst, which as you testified yesterday, represents the best judgment of the State, the region, and county governments of what can be done in the next year and one month.

I have placed on the stand in front of you five exhibits, 33 through 37, which were before you when we closed yesterday.

Those are, are they not, the letters of response from the five county administrators to your request or direction to them in February of this year that they submit a needs assessment and budget projections on deinstitutionalization for their respective counties?

You had an opportunity yesterday afternoon to look those exhibits over, did you not?

A. No, I did not.

Q. No, you didn't?

A. No, I didn't.

Q. Will you take that up now then?

What I want first to review with you are the number of community-living placements that each county in response to your direction presented to you with budget projections.

Can we take the county by months?

A. Sure.

Q. Montgomery County, and that's Exhibit 33, responded with plans and budget projections for community residences and services for 130 Pennhurst residents, did they not?

[27-5] A. This document was not in response to the request that the region had made. In Montgomery County the February 28th document simply identifies the needs assessment and budget projection for

all people residing at Pennhurst. It does not pertain to what their capabilities are for '77-'78.

There was a subsequent document —

Q. Go ahead.

A. — which describes that in response to the original request and that is a March 8th letter.

Q. Do you have that document with you?

A. No, I don't, which identified some of the people that would be served, the types of residential-support services, day-program services, and the source of this money that could be additionals.

In addition to this particular documents, Montgomery also sent in a similar document for individuals they had placed in institutions outside, out of Pennhurst.

Q. The second document you speak of is dated March 8th, did you say?

A. That's correct.

Q. And the letter you have in front of you, which is Exhibit 33, is dated February 28th?

A. That's correct.

Q. Now how did Mr. Manning chance to send to you a letter dated February 28th which lays out plans for community services and their costs for 130

—

[27-6] A. Okay. This was something that Montgomery County had done on their own and not in response to the Southeastern Region.

Q. What is the date of the request by your office by you to the counties, that they submit to you their needs assessment and budget projection on deinstitutionalization of Pennhurst?

A. As I said yesterday, the request began at a meeting at Deputy Secretary Hobbs' office on January 12th.

There was a follow-up meeting that I had with the county administrator on the 27th of January.

My assistants made phone calls, one of which was to Montgomery County, on January 28th and as a follow-up to that, then on February 4th we sent out a memorandum in follow-up to that telephone.
Q. That was the date of the memorandum sent to the five counties?
A. Yes, but this particular project that's in front of us was being compiled long before.
Q. All right, all right. You can come back to it if you wish. —
A. This is not their response to the region's request.
Q. Though it came after those conversations with the county and after the February 4th memorandum asking for a needs assessment and cost projection?
A. But this was — this particular project was in the works prior to those statements.
Q. What was prior?
A. This exhibit that you give me. Following this exhibit, it is coincidental. The dates are coincidental.
[27-7]
Q. Wait a minute.
It is dated February 29th?
A. That's right.
Q. PARC 33, a letter from Mr. Manning to you?
A. Right.
Q. And you say it was in the works long before January, the first part of January?
A. This is not in response to the regional request.
Q. I heard you say that, but more recently you said that that letter was in the works long before early January of 1977.
A. Based on my communication with Montgomery County, I have a particular date that they were doing their part of what they identified as their ongoing responsibility, and that it would be done not only for Pennhurst Center but for other individuals who were residing in institutions throughout the State.

Q. Who was it from Montgomery County who told you that the county was doing that?
A. Well, this is in my contact with Mr. Manning, who is the —
Q. Mr. Manning?
A. Yes.
Q. And when was it that he told you that Montgomery County was preparing a plan and cost projection for people who had originated in Montgomery County, who presently were living in Pennhurst and other institutions?

[27-8] A. I do not have a specific date. I just know that that was occurring.
Q. Did you know last fall? Did you know last summer, or did you know a year before that?
A. I don't have a particular date, but I know that it was being done prior to the request, the specific request for '77 —
Q. Prior to January of this year; and was Montgomery County doing this on their own initiative?
A. That's correct.
Q. Your office had not asked Montgomery County or any other county to do any such thing?
A. No. That's part of their responsibility.
Q. What do you mean, that's part of their responsibility?
A. The base service units, through the county, are mandated by the act to assess, to plan, to direct and coordinate the delivery of services for those individuals in Montgomery County.
Q. Has any other county ever presented to you a plan and a set of cost projections for residences and community services for the total population by origin from that county in Pennhurst State School and Hospital?
A. Not in that detail, no.
Q. Not in that detail?

When did they present to you such plans, albeit not in that detail?

A. Who?

[27-9] Q. The other counties.

A. I don't have specific dates, but there have been requests for funding in order to serve a specific population of people.

Q. That wasn't my question.

The question was have any of the other counties at any time presented to you a plan and cost projection like that Montgomery County plan for all of the residents at Pennhurst who originated in that county?

A. No.

Q. No?

Montgomery County undertook this not on request of the regional office nor on the regional office's direction, but on their own?

A. That's their responsibility.

Q. That's their responsibility.

You are saying that they have the responsibility to do that?

A. That's correct.

Q. When are the counties supposed to do that?

A. That's an ongoing responsibility.

Q. Ongoing?

Are they supposed to discharge that responsibility yearly?

A. No.

Q. When are they supposed to discharge it?

27-10] A. They don't discharge that responsibility.

Q. That, I think I appreciate very well; but you said it was the responsibility of all counties to prepare that kind of a plan?

A. No, it is not.

Q. What is it their responsibility to do then?

A. Their responsibility is to assess the individuals

who are mentally retarded in that county, to develop plans for them, —

Q. I see.

A. — to have an ongoing relationship with them regardless of where those individuals are placed; and they are to coordinate the delivery of services that impact upon the individual regardless of where the placement is.

Q. I see.

And the counties are responsible for doing that for each person who may have originated in the county who is at Pennhurst or any other institution?

A. Correct.

Q. And they are responsible then for having or maintaining a plan like Montgomery County's Exhibit 33?

A. Not necessarily in that format.

Q. Not necessarily?

A. Montgomery County chose to do it in that form.

Q. What form have other counties chosen to do it in?

A. What form?

[27-11] Q. Yes.

A. Some of them have requests for specific funds for different types of programs.

Q. I am sorry, we may be repeating —

A. I think we are.

Q. — but I want to be very sure that I understand what you are saying.

Has any other county ever presented to you a plan for residential and other community services along with cost projections for all of their residents at Pennhurst?

A. And I stated no to that originally.

* * *

27-32] [BY MR. GILHOOL:]

If the Pennhurst budget was deployed into the five-county area for CLAs and supporting services, would that, in your judgment expand the capacity of the mental-retardation system in the Southeast Region to produce CLAs and supporting services?

A. Obviously, that would.

Q. Have you or has your office ever determined how many providers of community-living arrangements there are in the five-county area?

A. The number of providers? I don't know that, the number.

Q. Would twelve seem to be about the right number, eleven non-profit institutions and one profit institution?

A. Mr. Bilyew would have that information. I don't have that.

Q. Do you have an idea of how much — is that the right magnitude? Are there about twelve providers or do you think —

A. No, there's many more than that.

Q. I am not talking about the number of group homes. I am talking about Ken-Crest, for example, that runs —

A. I don't know the number.

Q. You don't know the number?

A. No, I don't. I wouldn't want to guess.

Q. Whatever the number, have you or has your office ever called all of the present providers of those 500 CLAs developed over the last four years together to say something like we must and we want to expand the system as far as we can: please come back to me in, say, two weeks and give me your best

27-33] judgment of how many community-living arrangements you could have on the street, so to speak, that you could produce for me in the next year?

Have you done that or has your office?

A. No. The contract between the CLA and the county is with the county commissioners.
Q. I see.

It is the county commissioners' responsibility to do that?
A. The contract is between the county commissioners and the particular provider; and the county commissioners' arm is the MH-MR administrator and his particular program.
Q. Has the county, to your knowledge, ever called all of the providers together and said tell me how much you can do?
A. I don't know if they have or not. That would be more appropriate to ask the counties.

* * *

[27-37] Q. All right.

Now let me take you back to that Montgomery
[27-38] County letter that you received, that you testified was not in response to a request of yours.

However it orginated, that letter made out a plan, did it not, and costed that plan out for community services for 130 Pennhurst residents; right?
A. That's right. They didn't talk how many people could be dispersed and in what time frame.
Q. Of course, I don't want to go into that.
A. It was a needs assessment and budget projection.
Q. I don't intend to go to the time either, so you are really talking about something else.

That letter costed CLAs and community services on an annualised basis for those 130 Pennhurst residents, delivered to residents in the community at $1,900,000 annually?
A. I don't know. If that's what the figure is.

Q. You have the letter in front of you.
A. What exhibit?
Q. Our Exhibit 33, and that submission also said that the cost at then current costs of maintaining those 130 people at Pennhurst would be $2.8 million, almost $2.9 million on an annual basis; isn't that correct?
A. That's what is hand-written down at the bottom here.
Q. So that —
A. I don't know if that's the true figure, by the way.
Q. What is your opinion about that?

[27-39] Montgomery County has said that for 130 it costs nearly $3 million at Pennhurst for a year and for 130 in the community it would cost nearly $2.8 million.

Is that consistent with your notion of what it would cost?
A. I would say that to maintain an individual at Pennhurst and be able to serve an individual in the community, that it would be less expensive. I don't know how much less, but it would be less expensive.

I think that's basically what this indicates.
Q. Do you find order-of-magnitude difference — almost three million as compared with almost two million?
A. I don't know how to compare them. It seems that it would be almost a million less.
Q. So if the entire Pennhurst budget of — did you say $31 million in your testimony?
A. I don't know. I'd have to pull that figure.

MR. WATKINS: $32,302,000.

MR. GILHOOL: Okay.

BY MR. GILHOOL:
Q. If that entire budget were deployed to provide services in the community, then your testimony is

that it would more than cover the cost of community-living arrangements and other services necessary and proper in the community for all of the residents of Pennhurst?

[27-40] A. And if you took into account, assuming that took into account deploying official funds as well, and realizing that somewhere between seventy-five and eighty percent of those are in staff, and that the majority of the remainder are operational costs to maintain the buildings, obviously, there would be some difficulties in deploying the money, which means deploying the staff, as you well know, the unions involved.

If you are putting all of that aside and saying that there are no problems inherent in displacing 1562 staff and you are talking about a pure dollar figure of $31 million, that would support that population in the community.

Q. So that your answer is yes, there would be money left over after deploying the budget from providing community services for all of the people transferred out?

A. If the staff could be deployed appropriately and there would be the day services and the support services available through that, yes.

Q. Now is the plan complete? Have you prepared any plan for the deployment of Pennhurst staff to the community or their retraining?

A. No.

Q. When you say you haven't do you mean to say the regional office hasn't prepared such a plan?

A. That's correct.

Q. And Pennhurst has not?

[27-41] A. That's correct.

Q. And the State department has not?

A. The State department?

Q. Has not?

A. DPW?

Q. Yes.
A. Correct.
Q. And I take it the counties have not?
A. I would say that's correct.
Q. Have you ever read the McDowell report?
A. When I first came.
Q. When you first came?

Do you recall that that report in 1971 said that a necessary condition of actually achieving community services sufficient to displace or to replace Pennhurst would be the careful preparation and execution of a plan for placing Pennhurst staff in jobs in the community?
A. That would have to be critical since most of the money is staff.
Q. Right.

And the report said the very same thing in 1973, did it not?
A. Correct.
Q. Are you a student of documents like that, the Governor's Management Review?
27-42] A. I have not read that.
Q. You have not?

Would you be surprised — would you expect, indeed, that the Governor's Management Review undertook a careful review of mental-retardation services, institutional and community? Would you expect that such a review would have listed very high among its recommendations a definition in precise and concise terms of a plan and of procedures to transfer State institutional employees to community programs?
A. Is the question would I be surprised?
Q. Would you expect a review of that depth and intensity to come to that recommendation?
A. As a necessary part.
Q. But to your knowledge there exists now and has not existed since 1971 any such plan?

A. Well, I think it is important to note that Secretary Beal has requested a budgetary freeze 1975-76 to 1977-78, that, there will be single-stream funding.

I think there has been ample testimony about some of the difficulties with the numbers of appropriations that affect the institutions and the counties and, obviously, if there was single-stream funding some of the problems would be eliminated.

However, the request of Secretary Beal for the past three years has not come to fruition.

[27-50] * * *

[BY MR. GILHOOL:]

Q. Let's turn now, Mr. Rice, to the other aspect of the plan which you submitted yesterday, and that
[27-51] was headed "Institutional Internal Reform."

The two parts, are they Mr. Rice,

A. The two parts what?

Q. The two parts, the community facilities to reduce the size of the population at Pennhurst for fifty, and several million dollars for improvements at Pennhurst are really quite closely related, are they not?

A. Correct.

Q. And really this is a plan for an institution of 850 to secure federal Medical Assistance funds, isn't it?

A. That is part of the plan. The other part is the dispersal.

Q. It just so happens that —

Well, where did the 850 come from? Why 850?

A. As I described earlier, there were meetings at Pennhurst in April, I believe, —

Q. Why 850? Why not 1,000? Why not 500?

A. The care standards, the Medical Assistance, ICFMR regulations identify, as you see here on page two, certain things that must occur and, as you

see, much of that impact is on the living area, the bedroom area.

Q. All right.

A. Taking those care standards into consideration, an architect from DPW sat down with the program people from Pennhurst, the regional and the central office; and with those care standards in mind and with blueprints for every building, every area at
[27-52] Pennhurst, sat down and superimposed the care standards regulation on top of those blueprints and the life safety code regulations.

As you see, one of these is that a bedroom will accommodate not more than four persons.

Q. Yes.

A. Now, as I described earlier, some of those bedrooms are for three, two, one, based upon the program and the needs of the individuals.

That process identified, after every building was done in that fashion, in getting the pieces of furniture in there and the like, an 850 figure as the maximum population under the Medicaid standards.

Q. 850 is the figure at which you could qualify the total institution at Pennhurst for Medicare?

A. That's correct.

Q. How have you asked a preliminary opinion or any advice of HEW, the Title 19 administrators, about whether 850 will qualify all of the institution for Medicaid?

A. The information we have is that that will be — that figure will be an appropriate figure.

It says a maximum of four and I described some have three, some have two, some have one.

Q. Incidentally, you have been advised, to your satisfaction at least, that you will qualify at 850?

A. Based upon the process we went through.

27-53] Q. All right.

At the time of your deposition on March 14th of this year, at page 137, you said that the size of

Pennhurst would be 1,004, and that that size would qualify Pennhurst for federal Medicaid funds.
A. That was our — we had done some preliminary work prior to having the services of the DPW architect.
Q. Yes?
A. And taking into consideration that an individual could be placed in a particular residential area below the maximum of four, and utilizing at Pennhurst and the region and the central office what the more appropriate total would be, we come down to a figure of 850.
Q. Okay.

Now, as long ago as September 1st, and I am reading from the minutes of the MH-MR, which are Exhibit 44 — at that time too, according to these minutes, you reported that a population of 1,000 would qualify Pennhurst for Medicaid.
A. That was basically the thinking. I think that was a different statement.
Q. So the move was made from 1,004 to 850 because on rethinking 850 is what was necessary to qualify for federal Medical Assistance funds; is that correct?
A. As I said, there has been additional effort put forth, additional individuals involved, an architect
[27-54] involved; and again utilizing the care standards as defined we came up with a figure of 850 individuals.
Q. All right.

And that will go for Medicaid?
A. Yes.
Q. Now you testified at the very beginning to presenting a plan that is being developed with extensive consultations with Pennhurst staff and the other actors whom you identified, and that includes presumably Superintendent Youngberg?
A. Very critically in the interim reform.

Q. Now were you in the courtroom late last week when Superintendent Youngberg testified?
A. I was not here.
Q. Do you have a report of his testimony?
A. I have had brief summaries, yes.
Q. Did anyone tell you that Superintendent Youngberg testified —

MR. GOLDBERG: Objection, but go ahead.

BY MR. GILHOOL:

Q. — testified last week that the size of Pennhurst was to be 1,004 and further testified that he had not heard or participated in any discussion of a size of 850?

THE COURT: Do you have an objection?

MR. GOLDBERG: Your Honor, that's asking for a hearsay statement as to whether someone else told the witness something.

[27-55] THE COURT: You may rephrase the question by saying are you aware that the superintendent testified in this courtroom.

BY MR. GILHOOL:

Q. Are you? Are you so aware?
A. I am aware that he did testify?
Q. Are you aware that he testified that 1,004 was to be the size of Pennhurst?
A. Last week?
Q. Yes.
A. No, I am not aware because he was involved in this time period in April 20 - 22, involved in a sponsor —
Q. Is there any explanation why the superintendent would have testified last week 1,004 and would further testify that —

Let this stand for itself, he did so testify.

MR. GOLDBERG: Where? Have you the page in the record where he testified?

MR. GILHOOL: No. I don't have daily copy.

MR. GOLDBERG: Then I must object to the question because I don't see where you can show that that was the testimony.

The witness has already stated he doesn't know what Dr. Youngberg testified to.

MR. WATKINS: I don't know what the relevance of it is.

MR. GILHOOL: The relevance of it, your
[27-56] Honor, if I have to state the obvious, is that Mr. Rice said this plan was prepared after extensive and careful consultations and as recently as last week one of the prime consulters testified that he had never heard of the 850 and the institution, by his expectation, was to be at 1,004.

[27-61] * * *

[BY MR. GILHOOL:]

Q. Now apart from the physical requirements of Title 19, receiving federal funds under Title 19, does Title 19 require individual habilitation plans for each resident of a qualified institution?

A. Yes.

Q. Yes, sir.

A. Yes, sir.

Q. Do you intend to provide individual habilitation
[27-62] plans for each of the 850 who will reside at Pennhurst?

A. We intend to provide what is necessary to meet the minimal ICFMR regulations.

Q. So you do intend to provide individual habilitation plans?

A. Correct.

Q. Will these individual habilitation plans be provided by the base service units or will they be provided by Pennhurst staff?

A. In conjunction with.

Q. Pardon me?

A. In conjunction with.
Q. I don't understand.

Do you mean both Pennhurst staff and base service unit staff will assess and draw the individual habilitation plans and otherwise do all of those things necessary?
A. Correct.
Q. All right.

Now what additional staff will this require in the base service units?
A. I think you should ask an administrator.

* * *

27-65] * * *

[BY MR. GILHOOL:]
Q. Mr. Rice, I am not asking you about the people in the community. I am asking you about the 850 people whom you intend to keep at Pennhurst.

You have agreed that there must be individual habilitation plans for each of them. You further said that it is your intention to provide them. You have further said that the individual habilitation plan assesses all of the work that must be done and that will be done jointly by the base service unit and Pennhurst.

My question now is how much additional staff
27-66] is it going to require to do that?
A. I don't know how many additional staff it will require.
Q. Do you know how much additional staff it will require at Pennhurst?
A. For the population of 850 people?
Q. No, no, for individual habilitation plans.
A. Let's assume a new figure—
Q. Is it your understanding that fewer than ten percent of the residents at Pennhurst currently have an individual habilitation plan?

A. Fewer than ten percent?
Q. Yes.
A. That is not my understanding.
Q. What is your understanding?
A. That it is greater than ten percent.
Q. What is your understanding with respect to the base service unit's participation in the formulation of habilitation plans for Pennhurst residents?

Is it your understanding that fewer than ten percent of the residents have had base service unit participation in the formulation of a plan for them?
A. I don't know the figures.
Q. Does ten percent seem about right?
A. I don't know what the figure is.
Q. You testified that it had been the base service
[27-67] unit's responsibility and, indeed, it has been under regulations since 1968, has it not?
A. Correct.
Q. Do you know whether that responsibility has been discharged to the 1200 people at Pennhurst?
A. Totally? I don't know if that has been discharged totally for a hundred individuals.

I think that questions about county possibilities should be directed to the county administrators.
Q. Do you have the responsibility under the act to enforce the regulations of the State department with respect to the counties?
A. That's correct.
Q. And one of those regulations says the base service unit shall prepare life management plans, individual habilitation plans for residents originating there who are at institutions such as Pennhurst.
A. Correct.
Q. And that has been correct and approved since 1968, hasn't it?
A. Yes.
Q. Do you know whether the counties are in compliance with that regulation or not?

A. I don't know if they are totally in compliance, no.
Q. Would you expect that fewer than ten percent of the Pennhurst residents have had base service unit participation in any planning for them at Pennhurst?
27-68] A. As I have testified, I do not know.
Q. All right.

Well then, I guess now I understand why you can't tell me what staff or what the cost of individual habilitation plans are.
A. I think you have to go to those individuals who have that specific information.
Q. Yes, sir, but —
A. And that would be the superintendent and the county administrators.

I can't have all of that specific information. It is obviously staff that work for me, and there are staff in the counties and the institution who have that individual data.
Q. Did you go to them for that information?
A. Did I what?
Q. Did you go to the people you have just mentioned for that information?
A. What information?
Q. The information you were just addressing.

You said I should go to the superintendent and the counties for that information.

My question to you is have you gone to them for that information?
A. I have not gone to them for that information.
Q. Okay.

27-70] * * *

[BY MR. GILHOOL:]
Q. Right. It was never asked specifically.

Mr. Rice, does Medicaid require five and a half hours of active programming for each person at Pennhurst?

A. No.
Q. You intend to provide five and a half hours of active program for everyone at Pennhurst?
A. We would intend to, yes.
Q. In this plan with this budget, this staff, this cost, —
A. I have reported a number of times this plan will meet minimal ICFMR regulations.

The information that we have regards a minimum number of two and a half hours of what the standards identify as dead time, without any services.

The intent is to go beyond that as far as possible with the additional staff and with reorganization we
[27-71] intend to go beyond the two and a half, 2.75 hours of individualized structured programming, and we do intend to reach a five — five and a half, whatever is appropriate for that particular individual.
Q. When do you intend to reach five and a half hours?
A. First we have to reach two and a half hours.
Q. All right.

I am not interested in your intentions as to the far future; I am interested in your intentions in this plan that you have prepared for this Court.

In this plan will you provide two and a half hours of programming a day? Will you provide five and a half?
A. Minimally we will provide 2.75 hours per day, with the instruction of the staff that will be increased to over three.

And again the intention, first we have to meet the minimal requirements and then we will have the increase, whatever is appropriate for that particular individual, recognizing that the five and a half might not be appropriate for every individual — maybe more, maybe less.
Q. The plan is a three or four-page plan. That plan

includes the provision of 2.75 hours of active programming daily for 850 residents at Pennhurst.

Is that your testimony?

A. Minimally.

Q. Minimally? All right.

A. And with the statement I have already said, that
27-72] in a relatively short period of time we can increase that with redeployment of staff.

Q. All right.

And what is your understanding of the current average hours per day of active programming for Pennhurst residents?

A. Presently?

Q. Yes.

A. One and a half hours up to two.

MR. GILHOOL: I think the record will bear me out. I think the record will show that the highest number of hours of average programming at Pennhurst in testimony by any witness for the defense —

MR. WATKINS: Your Honor, is he arguing with the witness? He got an answer.

I wish counsel would get on with his cross examination.

THE COURT: If you are going to ask a question, ask it please.

MR. GILHOOL: Your Honor, I am trying to lay the basis for the question.

BY MR. GILHOOL:

Q. If it is one and a half hours presently, what is the additional cost in staff in dollars to raise that progamming to the 2.75 hours?

7-73] A. It is shown in the report. With the reduction to 850 people and an increase of $159,950.

Q. I understand that, but what is the net addition to program staff to raise the average active programming from one and a half hours to two and a half hours?

What's the gross figure? Now many more people are going to be working on programs.

A. On program and rehabilitative services, that would be an increase of twenty-three people over the existing complement of today. As described, it is eleven additional staff plus redeployment of the existing complement.

Q. On October 4th of 1976 did you not address a letter to Mr. Vincent J. Fitzpatrick, and this is PARC Exhibit 32, I say this with counsel's permission to expedite.

Did you not write Mr. Fitzpatrick, the president of the Pennhurst Board of Trustees, in order to satisfy both DPW's goal of institutional reform in 1977 and the minimum intermediate care standards Pennhurst must utilize its staff to further the programs' velocity by providing at least five and a half hours a day of structured programming, five days per week, and better utilize staff to increase the quantity and quality of weekend activity?

A. And I think I covered that quite extensively in deposition. I was asked that specifically; and the intent is to reach the five and a half.

[27-74] First, we must meet minimal ICFMR regulations. It is covered quite extensively in the deposition.

Q. But in the letter you said in '77 to meet minimum care standards you must provide five and a half hours.

Now you are telling me that while you have a hope, you have planned and projected providing 2.75 hours before December of 1978 or before July 1st of 1978.

Now which is it?

A. The intent is to meet first the minimal ICFMR standards and beyond that to provide the necessary programming.

If that translated into five and a half, fine.

The intent has been first to meet the minimal standards. That was explained to the Board of Trustees at a meeting with Dr. Youngberg, who was present, and that was explained in my deposition.

Q. How many additional staff, and what would they cost, would you require at Pennhurst to meet five and a half hours?

A. It depends on the population of people.

Q. For 850?

A. For five and a half, I don't know what it would take to meet it.

Q. All right.

And meeting five and a half hours is not part of the plan presented to this Court for an institution of 850 planned through July of 1978; it that correct?

[27-75] A. That's correct. The plan is to meet the ICFMR standards.

Q. Now why the change? In the October 4th letter you said to me to meet the ICFMR standards we have got to have five and a half hours of active programming.

For it is the premise of your plan that you don't.

A. As I explained in deposition, the intent was always to provide the five and a half.

Obviously, we first have to meet minimal standards. That has not changed.

That was made clear to the Board of Trustees, certainly to the Board as well as the superintendent who was there as well.

Q. In October of 1976 you wrote to Mr. Fitzpatrick that ICH, Title 19 standards, require five and a half hours of programming and yet in this plan you are going to reach only 2.75.

A. The Board of Trustees —

MR. WATKINS: Excuse me.

Could counsel please show that portion of the deposition? We all know where it is, but possibly the witness would like to see it.

MR. GILHOOL: Or he is going to have to be asked the question a half a dozen times, I suppose.

The question will be asked if it is answered.

[27-76] THE COURT: May I ask a question?

BY THE COURT:

Q. Are you testifying now that you consider the minimum standard now to be only two and a half hours?

A. That's correct.

Q. Did you at that time, when you wrote that letter, consider the minimum standards were five and a half hours?

A. Following that letter it was clarified that it was two and a half hours.

Q. In other words, is it your testimony that that letter was not an exact statement of what the minimum standards are?

A. That's correct; and that's what I said here.

THE COURT: All right.

Let's proceed.

BY MR. GILHOOL:

Q. And it was after that that you discovered then that these plans were for 2.75 instead of a plan for five and a half hours?

A. To meet minimal Medical Assistance standards; correct.

Q. All right.

Now you did say the MA standards accept two and a half hours of program —

MR. WATKINS: Your Honor, that's the same question.

MR. GILHOOL: No, it is not.

The JCAH standards — this is a question about JCAH standards requiring more.

[27-77] THE WITNESS: That was also in the deposition.

THE COURT: Let's answer the question. If you know the answer let's hear it.

THE WITNESS: I don't know what figure; as I reported, I don't know if it is five and a half.

I believe my deposition says that it is closer to the five and a half than the two and a half.

MR. GILHOOL: All right.

THE WITNESS: It is not usually translatable even with the JCAH standard.

It is based upon the individual treatment plans and how they are carried out, which for some individuals might translate into only three or four hours of structured programming.

So it is not very easily translatable in JCAH.

BY MR. GILHOOL:

Q. Your understanding is that the JCAH standards do not require numerical hours of actual programming?

A. They do not translate into so many hours; that's my understanding.

Q. You were asked also on deposition do you know of any professionally-acceptable standards, any other than what we have talked about, which would accept two and a half hours for minimum hours of active programming for residents of an institution like Pennhurst; and your answer then was no.

Is that your answer now?

27-78] A. That's correct.

Q. With respect to your own professional standards, Mr. Rice, would you accept two and a half hours of active programming for 850 residents of Pennhurst or, indeed, any mentally-retarded person as providing an appropriate service and habilitation for such a person?

A. Me personally, professionally?

Q. Yes.

A. As I stated in the deposition, the two and a half hours is minimally acceptable.

Professionally, I have concerns about that particular figure, but to me —

Q. Two and a half hours is minimally acceptable in that it meets ICH, Title 19, but it is not your own professional opinion?

A. That would depend upon what was needed for that particular individual. Generally two and a half doesn't — for myself professionally, two and a half hours, myself professionally, no.

Q. Now would you, as a Commissioner of Mental Retardation of the Southeast Region, approve a proposal for a community-living arrangement program which represented that there would be available day-program services of no more than two and a half hours a day?

A. Speaking very generally, it would depend upon the individual, that particular living arrangement.

[21-79] It is very difficult to respond to that type of —

As I reported before, particularly as identified in JOAN, it depends upon what is available for that individual, recognizing that an individual could receive so many minutes of occupational and physical therapy and as part of the planned program he might have a rest period of an hour, let's say.

That, to us, would suffice as part of his planned program.

Q. Don't you, as a matter of practice, require, before you approve any CLAs are opened, appearances of day programs that extend at least five and a half hours a day?

A. (There was no response.)

Q. Why else have we heard so much —

MR. WATKINS: Your Honor, he is asking a second question.

He has to wait until the witness answers the first one.

MR. GILHOOL: I will be glad to wait.

BY THE COURT:

Q. Can you answer the first question?

A. The averages are difficult to respond to. What I would respond to is that it does require an appropriate day program for that individual.

BY MR. GILHOOL:

27-80] Q. Yes, and in an appropriate day program —

A. That does not always translate into five and a half hours.

Q. Of course, it doesn't, but for the overwhelming number, approaching the proverbial 99 and 44/100s percent of retarded people, an appropriate day program exceeds five and a half hours a day, does it not?

Workshop programs, for example, exceed five and a half hours a day, don't they?

A. Correct.

Q. Schools exceed at least five and a half hours a day; isn't that correct?

A. Correct.

Q. Day-activity centers, funded by Act 256 funds, maybe one or two of which are open, exceed five and a half hours a day, do they not?

A. Possibly they do.

Q. And you require as a condition of opening any residence in the community that such day programs be available, don't you?

A. Correct.

Q. All right.

But it is not a condition of residence at Pennhurst that five and a half hours of day programs should be available, is it?

A. First, we have to meet the minimal standards.

Q. I understand that.

7-99] * * *

BY THE COURT:

I ask you this question as a professional, somebody that's apparently been educated in the field of retardation.

If you were given the complete authority and had the funds available and were in charge of a program, how long would it take you to transfer the 1200 residents that are now at Pennhurst from Pennhurst into appropriate slots in the community?

And I might add by "appropriate" I mean the type that you have been testifying that you think are necessary.

A. How long?

Q. How long would it take you, if we give you complete authority and you have the funds available?

How long would it take you to get the job done,

[27-100] forgetting about conflict?

A. It is not a simple answer; I can't give you that simple answer.

Obviously, a lot would have to go into a planning effort in order to disperse our people properly.

I can't give you a simple answer. I don't think it is fair to identify a specific time frame.

Q. You can't do that?

A. I can't do that now, no.

That doesn't mean I can't. I just don't have enough information.

Q. I just want to point out to you, of course, all through your testimony you have been talking about receiving plans, making plans, evaluating plans; and I didn't think that it was going to be such an unfair question and I thought perhaps that you could give an answer to that.

A. Well, —

Q. Do you still say you can't?

A. Well, I think this should be clarified, that I think my testimony has been that it has been the intent of the Department of Public Welfare that the commu-

nities be the responsible agency for dispersing individuals in the community.

The whole thing revolves around decentralization. The whole concept about the individuals who are closest to those mentally-retarded people would
7-101] be most sensitive to their needs and if they were served in the community, by the community, those individuals would have the sensitivity and the knowledge of what they would need and they would be accessible, more easily accessible.

Q. I know. I think I have understood your testimony to be that as far as the 1200 residents that are now at Pennhurst, it would be more beneficial in the future for each of them if they received appropriate care and services in residences in the community.

A. I don't think there is any — there is no argument there.

Q. There is no argument, but — all right.

There is one thing you just can't do and that is try to force somebody to give an answer, but your answer is —

Why don't you think about it over the weekend? I am not trying to get you to do additional work, but maybe it is just one of those things that if you thought about it the answer would come to you, you know.

A. It is very complex. It is a complex issue.

THE COURT: Well, yes. I suppose it is. See you Monday.

[28-3] * * *

BY MR. GILHOOL:

Q. Mr. Rice, we were examining county plans when we parted on Thursday and the particular matter on hand was the Bucks County plan for the next fiscal year, which you had testified was re-

ceived in your office a week ago last Thursday or Friday. As of last Thursday you testified you had not had an opportunity to look it over.

Have you had an opportunity since last Thursday to look at the Bucks County plan for '77-'78?

A. No, I have not.

[28-4] * * *

[BY MR. GILHOOL:]

Q. You testified that under the MH-MR Act each county must formulate and submit an annual mental-health and mental-retardation plan and costs; is that correct?

[28-5]

A. Correct.

Q. And that plan is submitted for the review and approval of the Department of Public Welfare, is it not?

A. Correct.

Q. In addition, the counties must submit annual reports on expenditures to the Department again for departmental review; is that correct?

A. Correct.

Q. And Section 512 of the Mental Health-Mental Retardation Act of 1966 says, does it not, if at any time after the approval of a plan the Department determines after hearing that such county or combination of counties is not complying with regulations promulgated under this act and that as a result the needs of the mentally-disabled persons therein are not being adequately met, the Department shall provide mental-health and mental-retardation services for such county and counties.

Is that correct?

A. Correct.

Q. Now during your tenure as Commissioner of Mental Retardation for the Southeast Region, and that has been since the summer of 1975, has the

Department ever disapproved an annual mental-retardation plan submitted by anyone in Bucks County?

A. Not to my knowledge.

Q. Has the Department ever refused finding for
[28-6] any programs in any of the five counties based upon the inadequacy of the annual mental-retardation plan?

[28-7] Q. And you have not been informed that during the earlier period the Department ever took any such action?

A. That's correct.

[28-11] * * *

[BY MR. GILHOOL:]

Q. Now you testified, I believe it was Thursday, did you not, that the base service units had the responsibility to draw and provide life-arrangements plans for each of their residents, including persons who are resident at Pennhurst who originate in that base service unit, and that those life-management plans must include individual habilitation plans and exit plans in the case of Pennhurst residents?

A. Correct.

Q. That responsibility of the base service unit originates in the 1968 regulations, in Section 522.1 and 522.2, does it not?

A. (There is no response.)

MR. GILHOOL: For the record, those regulations are PARC Exhibit 66 and if the witness wishes I will provide a copy to the witness.

May I show this to the witness, sir?

THE COURT: All right.

BY MR. GILHOOL:

Q. I place before you, Mr. Rice, PARC Exhibit 66 and show you the regulations effective November 15, 1968 and call your attention to 522.1 and 522.2;

and that is the source, so far as the 1968 regulations
[28-12] are concerned, of that duty of the base service unit to provide life-management plans for residents at Pennhurst, is it not?

A. Correct.

Q. The duty of the base service unit also has its source, does it not, in the February 10, 1973 regulations of the Department, which are numbered 5200, Appendix 4?

A. Correct.

Q. Now, Mr. Rice, were you in the courtroom when the following testimony was given or have you otherwise become aware of the following testimony:

Felix Roy, the first witness, I believe, for the Commonwealth, an employee for five years at Pennhurst and an experienced actor, testified that in the provision of training at Pennhurst he had volunteered to play any role at all — psychologists, social workers, team leaders, ward aid — but he could not play a base service unit representative because he had never seen a base service unit representative.

Were you in the courtroom for that testimony or have you otherwise become aware of it?

A. I was not in the courtroom. I received summaries on a daily basis of what occurred when I was not present.

Q. Now respecting the testimony and the same question, if you will, of Catherine Clark, the Director of Social Services at Pennhurst, who testified that a base service unit of a county mental retarda-
[28-13] tion office had been contacted for each resident at Pennhurst and asked to participate in the formulation of a plan for him and that that had been the policy over the last several years at Pennhurst, but that various persons in the base service unit had responded to that request.

Were you in the courtroom for that testimony or have you been made aware of that testimony?
A. I was not in the courtroom and I have been generally aware of the responses.
Q. The third piece of testimony from Dr. Betty Hare, based on the review of 120 records, a sample of one out of ten at Pennhurst — she testified that a review of those records showed that eighty percent of the residents at Pennhurst — their records showed no response and no participation by base service units and that only ten percent of those records, twelve out of the 120, and the same figure applies to the universe in which only ten percent of those residents had base service units participating, did you hear that testimony or have you been made aware of it?
A. I did not hear that testimony directly and again I have been generally made aware of people's testimony on a day-by-day basis.
Q. All right.

Now if that testimony and that evidence is correct, then Section 512 of the Mental Health-Mental Retardation Act providing that if the counties do not
28-14] carry out their duties under the regulations, the State shall —

MR. WATKINS: Objection, your Honor.

It calls for a legal conclusion.

BY MR. GILHOOL:

Q. From you understanding of the Section 512 of the Mental Health-Mental Retardation Act requiring that the State shall provide mental-health — mental-retardation services when the county fails, would that section obtain.

MR. WATKINS: The same objection, your Honor.

THE COURT: I think it is all right to ask him if he did understand it as the head of the department.

Do you call it the department or the bureau?

The WITNESS: The Department of Public Welfare, the Southeast Region.

THE COURT: He can answer whether it is his understanding and he can say whether or not this was the situation.

The WITNESS: I am saying that that could be applicable.

However, one of the other sections that's identified, either 508 or 509, Addendum 5, says that a particular county, if they feel they are unable to provide the specific services defined in the act, would seek in the Department for relief of that responsibility.

None of the counties have done so in my tenure and I don't have knowledge that that has been done
[28-15] in the Southeast Region.

MR. GILHOOL: Okay.

BY MR. GILHOOL:

Q. Your understanding is that the act would allow a county to petition the department to provide services which the county could not provide?

A. It was a possibility on a year-to-year basis if it can be justified.

Q. And a second device for the State actually executing the responsibility is for the State itself to give notice and hold a hearing and following the hearing to displace the county and provide the services?

A. If the county says they are unable to provide that particular service.

Q. Well, had your office or more generally had the Department, with respect to the five counties, on the basis of the failure of the base service units to carry out their duty under the 1968 regulations, the 1973 Appendix 4 of the regulations, ever withheld approval of a county's plan?

A. No.

Q. Has it ever withheld dollars from the county on the basis of a violation of those regulations?
A. It has not.
Q. And I take it has never given notice of a 512 hearing preparatory to the State providing those services itself?
[28-16] A. They have not.
Q. You, personally, as Commissioner, don't get to the base service units or the programs in the community to, in effect, investigate or explore their operations, do you?
A. No, I don't.

As I testified before, the responsibility for directing, controlling, and monitoring the base service units was purely with the county.

In my dealing with the county officers, however, I do not have any direct control over county programs.
Q. Now you leave it to the county offices to, in effect, investigate, monitor, and police the performance of the base service units; is that correct?
A. That's their responsibility.
Q. I am not asking you if that's their responsibility. I am asking you if that's a fact.

You never go the county offices to, in fact, investigate, monitor, and police base service units in the discharge of their duties; am I correct?
A. Correct.

Deposition of R. Rice

[68] * * *

Q. I take it, then, from your testimony that you've never recommended a decrease in the expenditure of monies?
A. That's correct.
Q. You've recommended increases, the expansion of programs?
A. Yes.
Q. Okay.

Now, what kinds of programs have you recommended expansion for?
A. My specific — recommendations haven't generally been made on a county by county basis, but have been made on a regional basis in terms of additional dollars in the base allocation. It's my belief —
A. The 43 Appropriation?
A. Right.

It's my belief that the county should be receiving funds generally, additional funds, across the board.

[69]

Q. For all the services that it should be providing?
A. Generally speaking, it can be for all types of — the county program, the county mental retardation program, in my estimation, is not receiving generally enough funds in order to —
Q. Presently?
A. Presently.
Q. When you say that the county programs are not receiving enough money, what do you mean?
A. Appropriation 43 and Appropriation 57 should be expanded significantly.
Q. Why should those appropriations be expanded significantly, as you put it?
A. One, to meet one of the basic intents of the mental retardation programs in the state is to provide as

many community-based residential and support services in the county program.

Q. So one of their reasons would be to institute the basic intent of the 1966 Act, as you refer to it?

A. Yes.

Q. Is that correct?

A. Yes.

Q. What other reasons? There's a fairly general reason, to meet the basic intent.

[70] A. Well, the reason was to provide as many community-based residential and support services to keep individuals as close to their communities as possible in terms of receiving services, whether it's in the home or whether it's in a residential program.

Q. The funds currently are insufficient to fulfill that purpose?

A. In my estimation, yes.

Q. Do you have a notion as to the amount of increased appropriations required to meet the purpose of the act as you've outlined it?

A. No.

Q. No general notion?

A. It runs in the millions of dollars. I would not and could not guess.

Q. Now, you've stated that you've recommended expansion of these community services generally, but not in terms of each of the five counties; is that correct?

A. That's correct.

Q. Is there an amount, figure that you've recommended generally throughout the five counties for this expansion?

A. No.

Q. How, then, have you made the recommendation?

A. It's been based on the recognition and the knowledge of the number of, to use an example, of

[71] individuals in state centers, that if there were a

continuum of residential and support services in the communities, that in the future there might not be a need for state centers for the mentally retarded, if the appropriate services could be provided in the communities with the appropriate amounts of money to support that.

Q. I'm a little lost on how you've made this recommendation.

A. Okay, how I've made the recommendation.

Q. Right.

In other words, we were discussing, when we got under this line of discussion, budgets and recommended increases, and, I believe, you've told me that you have no specific number in mind as to the amount of monies required for such an expansion but on the outline of criteria that you've just given, that expansion is recommended.

Now, how do you make that kind of recommendation or how have you made it?

A. Those recommendations have gone to Deputy Secretary Hobbs.

Q. In writing, I take it?

A. Yes, both in writing and in discussion.

Q. When would the last recommendation in writing have been made?

A. They are of a general nature, and I don't have any specific date.

[72] Q. When you say "They are of a general nature," what do you mean?

A. Of a general nature, in that I define what I perceive to be inequities in terms of the present system.

Q. Determine inequities?

A. Yes, inequities.

Q. What inequities are you referring to?

A. The way money is allocated in the Commonwealth in terms of mental retardation.

Q. Allocation inequities, do you mean?

A. Inequities in the allocation of available dollars.

Q. What are the inequities of the allocation of available dollars?

A. The basic funding strain. There is a financial incentive that the counties have to institutionalize people.

Q. An incentive to institutionalize people?

A. A financial incentive.

Q. In the counties?

A. For the counties, because the state appropriation is Appropriation 40, which serves the Mental Health-Mental Retardation facilities, and that's 100 per cent state-funded.

Q. By that, you mean that if someone goes to an institution, the state picks up 100 per cent of the tab?

A. Correct.

Q. If they're in a community program, the state
[73] picks up 90 per cent of the tab; the county 10 per cent of the tab?

A. Basically, yes.

Q. I take it that the 100 per cent, if you will, picking up the tab is the incentive to institutionalize?

A. I've defined that as an incentive to institutionalize.

Q. "Yes" is the answer?

A. Yes.

* * *

[95] MR. PEABODY:

Q. Now, have we outlined completely, then, the budgetary process for the county community-based mental retardation programs?

It seems to me we got with a lot of detail to the legislature and maybe I'll recount it, going back through the system again and see if I caught it all.

The legislature passed a bill, an enactment or a
[96] form of the Executive budget request.

A. Correct.

Q. That bill goes back to the Executive budget office for allocation —
A. Re-allocation for rebudget.
Q. Right.

Specifically for rebudget in cases where the appropriated figure is fewer dollars than those requested; is that correct?
A. Correct.
Q. Now, is it that if the appropriated amount is the same as the budget request, no rebudget or re-allocation would occur?
A. I would assume that's correct.
Q. They just go with what they've proposed, I take it?
A. Yes.
Q. Then it goes back through the secretary's office, back to the budget office of DPW, where additional breakdowns are made?
A. There's an entire rebudget process. Each one of these offices will do a rebudget.
Q. At the budget office level, it would again take on the contours of the region and the counties therein?
A. Yes.
Q. And then, from the budget office, it goes to the
[97] central office, back to the regional office?

In the case of 40 funds, definitely to the regional office, then, I assume, to the institution; in the case of 43's and 57's to the commissioners with a copy to you so that you'll know how much the counties are receiving?
A. The regions and the counties get them at the same time.
Q. So the process I've outlined is generally correct; is that so?
A. Yes.

* * *

121A] BY MR. PEABODY:

Q. Now, Paragraph 3 asks you basically for the Title 20 Plan, Commonwealth of Pennsylvania, and any other documents which will reflect how state funds are being matched to those federal funds.

Do you have such documents in your possession or control in the regional office?

MR. COOPER: There is an objection to that part of third request which asks for the Department
[122] of Public Welfare budget requests. As to the remaining documents, which include the Commonwealth of Pennsylvania Title 20 Plan, the Executive budget for the Department of Welfare, enactments of the legislature designate the amounts of money appropriated for the operation of such department, which reflect Title 20 allocations, i.e. the matching the state and federal funds, and Act 256 and developmental disabilities appropriations administered by DPW, there is no objection made, but apparently these documents are unavailable in the regional office at this time.

Q. Dr. Rice, you don't keep, as part of your work, the documents to current Title 20 Plans?

A. State-wide plan?

Q. Yes.

A. (No response.)

* * *

[123] Q. Now, are the various county-operated community-based mental retardation programs receiving Title 20 federal funds?

A. Yes.

Q. Could you explain briefly how they receive them?

A. Commonwealth receives an appropriation for Title 20. There are various categories in which that money can be spent. That is allocated to each region, and money can be spent in specific categories,

within the Southeast Region, within those particular objects.

Counties submit requests based upon their identified needs translated into dollar amounts that are necessary to meet those needs by objects as defined by Title 20.

[124] Q. Is this pursuant to the budgetary process you've outlined already?

A. Yes.

Q. It's part of that?

A. Yes.

Q. Now, to your knowledge, has the Commonwealth of Pennsylvania reached its Title 20 ceiling?

* * *

[125] A. I'm confused by "reached their ceiling."

My understanding is that they spend the money that is appropriated to them.

Q. They spend all they can get?

A. That's my knowledge, yes. It may not be to the penny, but I'm sure they make every effort and do spend as much as is appropriated.

Q. Do you have a notion as to how much of these Title 20 funds find their way to the community-based programs in the Southeastern Region?

A. No, but I can get you that.

For what year?

Q. '76-'77.

That would be reflected, I believe, in the '76-'77 plan.

A. Right. You'll find that in one of those breakdowns by category, by region.

* * *

[126] Q. Do you have documents in the regional office, described in Paragraph 4, namely, reports as to the amounts of Title 19 funds received, for the operation of Pennhurst during the present and past two fiscal years?

MR. COOPER: Apparently the Title 19 infor-

mation is not kept in the regional office. I'm not certain whether it's in the central office or not.

Q. Do you have knowledge as to where these records are kept?

A. They would be in the budget office, and it's part of the money that is defined in those budgets were defined in augmentation, as you have seen.

Q. Title 20 monies would be reflected in the aug-

[127] mentation column of the Pennhurst budget requests that I showed you. Title 19.

Q. Pardon me, Title 19.

A. That's part of the augmentation.

* * *

[135] Q. In response to questions from Mr. Peabody, you went over the various categories of budgetary requests and allocations that you analyze.

These included the base allocation, the community living arrangements' allocation, the institutional allocation, those three.

Are there any other specific budget categories or allocations which you review?

A. There's an FRS, which is categorically within the base allocation, and there is what is defined as Pennhurst dispersal, which is part of Appropriation 43.

Q. Are there any other categories of budget requests or fund allocations?

A. There would be Title 20.

Q. Is Title 20 within the base?

[136] A. No. There would be Title I DD, developmental disabilities, and this will fluctuate from county to county.

* * *

[138] Q. You also mentioned developmental disabilities, which is identified as DDS allocation is budgetary documents?

A. Yes.

Q. What is that?

A. That is money to impact on the developmentally disabled, and the classification is mental retardation.

Q. What is the process for individual counties re-
[139] ceiving developmental disabilities' money?

A. Last year or this year? It has changed.

Q. Let's start with last year.

A. Last year the regions were told that there was approximately X amount of dollars that would probably be available for developmental disabilities. We in turn contacted the county MH-MR offices and alerted them to the fact there would be developmental disabilities', monies, gave them a package of applications, procedures, criteria; in turn, they received applications from providers. They screened the proposal at that level to make sure it met the criteria procedurally and programmatically.

They prioritized programs they wised to fund, if they had the money. That information was sent to the regional office. The regional office met with each of the counties regarding their individual priorities that came up with the regional priority.

Based upon that priority around that particular time, the region is made aware of the amount of funds and we allocate it appropriately.

Based on the priorities and documentation of need —

Q. Who set the priority for allocations?

A. Initially it came from the county, and then there were negotiations between the region and the
[140] county as to the particular needs.

Q. Do you recall what the total amounts of funding, developmental disabilities' funding, for the last year was?

A. Initially — I'd rather get you — it was not a lot of money. There was much more effort put into it than money received.

Q. Generally a hundred thousand; a couple hundred thousand?
A. A hundred thousand.
Q. Do you recall what the priorities were in the expenditure of that?
A. The priority was to support individuals who were in community living arrangements' programs or in similar types of situations, living arrangements.

[27] **M. Knowlton — Deposition**

* * *

Q. You say you plan for different types of Community Living Arrangements. What are the types of Community Living Arrangements?
A. What are the types?
Q. Yes.
A. As I said earlier, there are currently seven types. The first type is what we call a Developmental Maximation Unit. That is a —
Q. Why don't you just tell me what the types are, first. You said there were seven types?
A. Right. That's the first type.

The second type would be Intensive Habit Shaping; third type is Structured Correctional; fourth type would be Child Development; fifth would be Adult Training; sixth Adult Minimal Supervision; and seventh would be Family Relief.
Q. Before we get into these types, is there a generic definition or description of Community Living Arrangement?
A. As a whole?
Q. Yes.
A. I don't think anything specific, other than residential facilities in a community that would offer
[28] the least restrictive environment, living environment in the most normalizing setting.
Q. They are basically residential programs as opposed to service programs?
A. The primary emphasis is residential, but in some areas there are specialized needs that have to be fulfilled through particular types of services being rendered to meet the needs of the individual.
Q. What types of clients does CLA serve in terms of age and developmental level?
A. The continuum of seven programs offers residential settings to all individuals that are mentally

retarded, no matter what their functional level and no matter what their age. Or secondary handicaps, for that matter.

Q. Are individuals excluded from Community Living Arrangement Programs in terms of any particular behavioral characteristic or disability?

A. On occasion, but not because of their disability that much, more so because the particular program that they may need is not available in the particular county, and they may have been improperly selected and gone into a community program and found out that that was not the appropriate program, so they may have been asked to leave because of that, gone to another setting.

Q. That is because a particular placement did not work out?

[29] A. Work out.

Q. But there are no prior criteria which could exclude a person from a Community Living Arrangement?

A. No.

Q. Community Living Arrangements serve both people who are now in the community and people who are in the institutional programs?

A. That is correct. We are looking at two things, one would be de-institutionalization, and two would be prevention. So we have had a basic policy over the past three or four years recommending that 50 percent of the residents come from the community and 50 percent of the residents come from the institution.

* * *

[54] Q. Earlier on you described the various types of Community Living Arrangements. You named then the various Community Living Arrangements. First was Developmental Maximation Unit?

A. Yes.

Q. What is that?

[55] A. That's a program that would serve either adults or children that have a primary medical need. That would be medically complex or multi-handicapped.

The major responsibility would be to work on the medical problem first, and secondarily, on going working to teach developmental skills to the individual.

Q. Is there a particular age range that this —

A. Well, the age range would be from birth to death, but we would divide children and adults, they wouldn't be in the same facility.

They could be any functional level. Again, the primary need would be medical.

Q. Would these be the people who are generally described as the more fragile and more severely impaired?

A. Well, it you are talking about physically fragile, yes. Again, it's physical problem. An individual could be profoundly retarded but not need or not have a need for medical type back-up.

* * *

[56] Q. How many people would one unit serve?

A. That could vary depending on how the county wants to operate the particular program. It could be anywhere from two to twenty, even thirty.

Q. Is there a maximum number?

A. The maximum number that we have set is twenty, but we have waived that in one instance and we are probably revising that in our regulations that we are currently revising now down to a lower number.

Q. What is the purpose of having a maximum number? For example, Pine Hill serves 150, 160 people.

A. Well, our concern was based on some pragmatic concepts as far as the larger their program the harder it would be to manage it, perhaps. We wanted more individualization, more normalized

living. Again, for the same people, as our trend
[57] throughout, offering the least restrictive type of living situations. We came to the conclusion that people that have that kind of need for residential services don't have to live in nursing home or medical facilities if they have the appropriate staff support in more normalizing and more integrated living situations.

Q. Is there evidence that a smaller facility makes a difference in terms of the growth development of the person and the care of the person?

A. Well, we are currently working with one provider in Montgomery County now, Lynch Home, which you may be familiar with, where they have in a home-like situation individuals that are medically complex, multi-handicapped, children, in fact, and we have recently funded them to disburse those same individuals with staff into smaller living units, apartments, things like that. The individual responsible for that program, who has had that particular program responsibility for many years, feels very clearly that, based on his experience and knowledge of working with these kind of people, that the less structured living situation would be much more appropriate to meet the needs of the individuals that he is currently serving.

Q. Are these types of people that you are describing in the Lynch Home the types of people that formerly would have been committed or admitted to Pennhurst or another institution for long-term care?

[58] A. They more than likely would be, if no other facility was available, because they have many severe kinds of medical problems and abnormalities.

Q. Were facilities like the Lynch Home available in April of 1972?

A. The Lynch Home itself was, yes.

Q. How many people did it serve?

A. I don't know. I would — I'm guessing somewhere between 15 and 20, though.

[60] * * *

Q. Another type of Community Living Arrangement you mentioned was Intensive Habit Shaping?
A. Right.
Q. What type of facility is that?
A. This again is broken into adults and children's units. This is to serve individuals that have severe acting-out behavioral problems, personal problems such as head banging, window breaking, a lot of emotional kinds of disorders. They are personally related. Severe toilet training problems, severe feeding problems, things of that nature.
Q. What are the characteristics of that type of facility in terms of staffing and program operation?
A. Well, there can be three different models for that type program. The one that we are most familiar with and have the most of now is generally a six-bed unit that would be staffed with people that are skilled behavioral therapists with a primary responsibility to extinguish the negative behavior and replace it with something positive. So the six-bed unit, that would be one.

Another type of facility would be an apartment facility with one or two children in an apartment and again, behavioral therapists living and working in the apartment with the children.

A third component would be moving the person that had those kinds of problems into a non-specialized program and having a core staff of behavioral therapists working with the staff and child, using a child as an example here, in a non-specialized program till the negative behavior was extinguished

[61]

and replaced with something positive, and then the core staff would leave and go somewhere else.

Q. Are there proven therapy or treatment techniques to modify behavior such as head banging, self abuse and in acting-out behaviors in retarded persons?

A. Things like behavior modification and other programs like that would extinguish that particular behavior. Another precision measurement, precision teaching, all fall into that same category.

* * *

[62] A. Well, right off the bat there is one that is funded to be a habit shaping in Philadelphia.

Q. Are there any in operation?

A. That one is, it's funded and in operation.

Q. It has people?

A. It has a Habit Shaping Unit, yes.

Q. Is that a six-bed unit?

A. Yes, for adults.

Q. The Habit Shaping Unit requires a particularly skilled staff component?

A. That's correct.

Q. Do these staff have to be hired by the county?

A. The staff have to be hired by the agency that contracts with the county, unless the county is providing the program themselves, then they would hire the person.

Q. Is the availability of staff any particular barrier to setting up this type of a home?

A. Yes, it is. It's one of the major barriers as far as the availability of skilled staff.

Q. This would be one of the program components that is 100 percent State funded, though, is that correct?

A. All of the Community Living Arrangement programs are 100 percent State deficit funded.
Q. The third type was Structured Corrective?
A. Structured Correctional.
[63] Q. What type of facility would that be?
A. This would be to serve individuals that had anti-social behavior, maybe potential or actual offenders. It could serve children or adults, but in separate facilities.
Q. Are there any particular program or staff requirements of this type of facility?
A. Well, we require that the responsible person for the development of a program have skills in dealing with anti-social behavior, have some kind of background in dealing with either adult or juvenile offenders.
Q. Are there any particular facilities constellations for this Community Living Arrangement?
A. We basically offer the same three settings as we did with the Intensive Habit Shaping; single homes that may serve six people, apartments that would be integrated and disbursed or a core staff with the individual, again, like Intensive Habit Shaping, be integrated into a non-specialized program with the core staff working with a regular staff and the resident.
Q. The next type you mentioned is Child Development?
A. Right.
Q. What type of facility is Child Development?
A. This would be a basic children's residential program for individuals from approximately birth to age, again approximately, age eighteen, and would
[64] serve those individuals that do not need a more specialized living situation but are basically there to learn developmental skills, social skills, and our direction here is to develop this particular setting as close as a normal home-like setting as possible.

Our primary emphasis is on small apartments or small homes, husband and wife teams and two or three children that would be operating that particular type program.

Q. These homes, the husband and wife team are actually the staff of the home?

A. Well, yes, but there are instances where there would be other staff that would be working part-time. In fact, the husband or the wife, either one of them could have outside jobs, but one would be responsible as a full-time employee. Generally it's the husband working out.

Q. What are the size of these homes or the size —

A. Well, of homes?

Q. How many children live in these homes, numbers?

A. Be more specific as far as the total amount of children in CLA or the amount we would allow in one home?

Q. The amount you would allow in one home.

A. A maximum of eight and that's very rare now. We are almost predominantly going to staff departments where we have generally two children. That's the preponderance of the children's development program.

[65] Q. Two children in one home or apartment staffed by a husband and wife team?

A. And any assistants that they may need.

Q. Children of these homes go to public school, generally?

A. Almost universally, except for some instances where the children may not be of school age. Then they would go to early childhood development class, pre-school.

Q. Those persons at Pennhurst between four and a half and eighteen of school age go to school during the day and then return to Pennhurst and receive

educational programming. What basically are the benefits of a child living in an arrangement as a Child Developmental Community Living Arrangement than living at Pennhurst?

A. Well, an individual as a child would have much more individualized attention because in most instances there would be one or two or even at the maximum eight, and the whole living situation would be much more normalized as far as the living situation within the home, within the community; as far as the individual would go to school within that community and go back to the home within the community; all services as far as dental, medical, religious, everything else that person normally receives in the community, this same child in the CLA programs in the community would receive. They would go out to the store with the
[66] houseparents and buy clothes and go to the market, buy food, go the barbershop in the community and get their hair cut, just lead the same type of life any other child would lead.

Q. Aren't there services that might be available to a person in a large institution that would not be available in the community, such as physical therapy or occupational therapy or medical services, all those services that you mentioned are available to any other person in the community?

A. I don't see where they wouldn't be available to someone who is mentally retarded.

Q. Do children living in Community Living Arrangements, in fact, receive these services?

A. I can't guarantee that everybody receives it, but it should be there. It's as good as our monitoring ability.

Our own accountability system, we ask that there be annual medical check-ups, dental check-ups; quite a few people that receive speech therapy

in CLA program and other kinds of therapy.
Q. The Community Living Arrangement that is typed as Adult Training, what is that?
A. That's for individuals that are age approximately 18 and over who would receive training in a residential setting to aid them in becoming more socially adapted within the community, give them homemaking skills, cooking skills, basic skills that
[67] individuals as adults would have to have to be able to live more independently in the community, communications skills, how to use telephone, transportation.
Q. How are these facilities staffed?
A. They are primarily staffed with adults who, in some instances, may be husband and wives in group homes and other instances may be husband and wives in apartments, or they may be staff of one sex; male programs might be males or females might be female staff. It doesn't necessarily always have to be a husband and wife team for adult programs.
Q. Are there a maximum number of persons to each facility on that type of living arrangement?
A. The maximum number is eight. Again, the numbers are going down as far as that type of setting. We are emphasizing smaller staff programs such as apartments for the adults as well as the children.
Q. Are these adults also in various programs in the community, service programs in the community?
A. We would expect the adults to be in vocational training programs on competitive employment.
Q. Is that a requirement of the program?
A. Yes. In fact, in our proposal format we have one page that a provider must fill out that specifies all the supportive services that are going to be available and who is going to provide them and who is going

to pay for them; medical, dental, religious, day programs and so on.

[68] Q. In other words, a provider could not provide an adult training living arrangement which would simply provide shelter and room and board for the adult and the adult might be sitting there all day?

A. Generally not, but in a few occasions it might be possible. Some examples would be there may be an individual that would come into CLA that's elderly and it may not be appropriate for that person to work, and that person may make the decision that he or she doesn't want to work and does want to stay at home and just interact on their own in the community or in that particular home.

Another example would be the case where an individual might come into a Community Living Arrangement program as an adult, enter a vocational training program and go through a year or two years in a vocational training program and all of a sudden the money might run dry to support him, and the person might have to sit home for a certain amount of time until the day program money went back into the particular vocational training.

Q. Those are individual circumstances. You would not approve of a home which would have, for example, eight adults without a program, with no activity?

A. No. Every program would have to offer something.

But to clarify a little bit more, quite possibly in some instances the individuals may not leave the

[69] home for the service. For example, the Developmental Maximation Unit, we may have to bring staff in there because the individuals' medical problem wouldn't allow them to leave the building.

Q. I was talking specifically about the Adult Training.

A. The Adult Training, they should not be at home other than the earlier reasons I gave.
Q. Adult Minimal Support?
A. Minimal Supervision.
Q. I'm sorry, Adult Minimal Supervision.
A. This is for individuals that are about one or two steps away from complete independence. In other words, no longer need State support or county support their living situation. They lack perhaps one or two basic skills, such as cooking or money handling, before they can live completely independently.

The primary responsibility there would be to concentrate on developing those particular major skills that are lacking and have the person leave the CLA program completely and live on their own.
Q. What type of staff do you have in the Minimal Supervision?
A. This would vary depending on the needs of the individual. It can be a living situation where two or three people that would be considered minimal supervision would live in an apartment with one
[70] person that was staff that would kind of work with them. Then as those people would develop their skills, the staff persons may leave or those residents may leave and move into some other apartment where they might only be visited by a staff person. Again, then depending on their needs it could be daily, it could weekly, it could be monthly, depending on how they progress.
Q. Is there a maximum number of individuals in each one of these programs?
A. I can't think of anything over six without, and generally that's two or three.
Q. I take it that there are people who enter into Community Living Arrangements, reside in those Community Living Arrangements for a time, then

move on either to independent living or to another type of —

A. Something less structured.

Q. Something less restrictive, is that the case?

A. Absolutely.

Q. Do you have any figures which would indicate how many people have moved from Community Living Arrangements to less structured —

A. That's on our monthly population report, to a certain degree, not exactly within the system. We don't have that movement, but we have the movement as far as people that come into CLA and then leave.

[71] I mentioned earlier we have 2,260 people in CLA at the end of January. CLA has served totally since April of 1972 almost 4,000 people. Now, of that difference, then, a good many of the adults have gone on to live independently. Many children have gone on to live at home, back with their family. In some instances some children have gone into foster homes.

We have had about 200 individuals, as an approximate, who we were not successful with in CLA and have gone back to public institutions.

Q. Have some of these individuals that have either moved to independent living or to live with their family or foster care, individuals who originally came from institutional programs?

A. Many of the individuals that have gone on to independent living were from institutional programs, but I don't have any specific breakdowns. I think the best thing I can give you there is just from my own experience in Nebraska when I was operating programs, that the people that seemed to benefit fastest and move faster through the program, whether it be into competitive employment or independent living were generally those people from in-

stitutions. They seemed to do much better than people from the community.

Q. Is that due to any particular aspect of the Nebraska program or to what do you attribute that?

A. I attribute it to perhaps two things; one, it would
[72] be the work that the institutional staff did with the residents and secondly, it appeared that many of the residents that came from institutions really didn't have to be there if something more appropriate was available. So it was, what we offered them was, they were just ripe for you know, rapid growth and development because we did give them access to —

Q. Do you have any reason to believe the situation is different in Pennsylvania?

A. I don't see anything that would tell me that it would be different.

Q. Any reason it might be different in Southeastern Pennsylvania?

A. No.

* * *

[73] Q. If there were no admissions to Pennhurst or commitments to institutions in the Commonwealth, would one of these types of Community Living Arrangements provide an appropriate residential placement for those individuals?

A. Yes. One of the seven, yes.

[102] Q. Of the over 2,000 people in Community Living Arrangements, do you have a breakdown on developmental level?

A. No.

Q. And entrance into the programs?

A. No, but —

Q. Do you have any basis for knowing what that is?

A. You can generally tell by the type of program.

If it's Intensive Habit Shaping, you can pretty much know that it's severe and profound.

Developmental Maximation Unit is generally severe and profound.

[103] The Adult Training would be generally severe and moderate.

Adult Minimal Supervision would be high moderate, mild. So there's patterns based on the type of program.

* * *

Supreme Court, U. S.
FILED
OCT 30 1980
MICHAEL RODAK, JR., CLERK

Nos. 79-1404, 79-1408,
79-1414, 79-1415, 79-1489

IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1980

Pennhurst State School and Hospital, et al., *Petitioners*

v.

Terri Lee Halderman, et al.

Pennsylvania Association for Retarded Citizens, et al.

and

United States of America, *Respondents*

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

JOINT APPENDIX — EXHIBITS VOLUME VI, A943-A1166

Petitions for Certiorari Filed March 12 and 20, 1980.
Certiorari Granted June 9, 1980.

THE LEGAL INTELLIGENCER, 66 NORTH JUNIPER STREET, PHILA., PA. 19107 (215) 561-4050

EXHIBITS*

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PARC Ex. 18	Comprehensive Mental Retardation Plan, December, 1965 (excerpt)	A943
PARC Ex. 21	Pennsylvania State Plan for Construction of Facilities for the Mentally Retarded, 1969 and 1970 (excerpt)	A946
PARC Ex. 25	April 12, 1972 Memorandum of Edward R. Goldman, Commissioner of Mental Retardation, Re: *Proposed Expenditure of all Capital Funds for Pennhurst (Questions raised regarding the proposed total dispersal of that institution by the end of fiscal year 1974-1975;* and attached memorandum of April 7, 1972	A948
PARC Ex. 26	Press Conference, Secretary of Public Welfare, Wohlgemuth, 12/14/72	A971
PARC Ex. 28	The Governor's Review — 1975, Sec. II "Welfare and Mental Health" (excerpt)	A974
PARC Ex. 33	Need and Assessment and Budget Projections on Deinstitutionalization of Montgomery County persons residing at Pennhurst Center	A983

*Exhibits included herein were admitted into evidence at Tr. 1-36 to 1-43; and Tr. 1-49 to 1-56 and at Tr. 4-68.

EXHIBITS* — *(Continued)*

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PARC Ex. 38	A Brief History of Pennhurst, 1908-1926, Compiled from Superintendent's Records	A988
PARC Ex. 40	Pennhurst in Perspective: Purpose, Programs, Possibilities	A996
PARC Ex. 45	Pennhurst State School and Hospital, Philosophy, Purpose, Goals and Objectives	A1000
PARC Ex. 48	Pennhurst Survey Results	A1003
PARC Ex. 54	Analysis of Programming History of Pennhurst Clients Proposed for Transfer of Embreeville	A1014
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PARC Ex. 56	Dispersal from Pennhurst State School and Hospital to Community Living Arrangements, to other Community placements, to Pinehill Center, to Embreeville, to Woodhaven and to other state facilities, 1972 through 1976, and Waiting List Statistics	A1016
PARC Ex. 58	Allocations, Expenditures, and Carryovers of State Funds for MH/MR	A1020
PARC Ex. 63	Definitions of Community Living Arrangement Types	A1029

*Exhibits included herein were admitted into evidence at Tr. 1-36 to 1-43; and Tr. 1-49 to 1-56 and at Tr. 4-68.

EXHIBITS* — *(Continued)*

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PARC Ex. 64	Community Living Arrangements Population and Dispersal Report — June 1976	A1032
PARC Ex. 65	DPW, Summary of Fiscal Activity, Fiscal Year 1975-1976 (August 20, 1976)	A1038
PARC Ex. 66	DPW Regulations, Title 5200 and Appendices, IV *County Mental Health and Mental Retardation Program: Service Content of the Program*	A1046
U.S. Ex. 5	Pennhurst State School and Hospital — Memorandum, May 15, 1975, Inappropriate Commitments	A1153
U.S. Ex. 15	Pennhurst State School and Hospital — Cumulative Accident Summary December 29, 1976 — January 29, 1977	A1157
U.S. Ex. 48	Index of Photographic Exhibits of Pennhurst and Community Programs	A1161

Photographs admitted into evidence as U.S. Exhibit 48 are presented in a separate volume.

*Exhibits included herein were admitted into evidence at Tr. 1-36 to 1-43; and Tr. 1-49 to 1-56 and at Tr. 4-68.

A943

PARC Ex. 18

Commonwealth of Pennsylvania

The COMPREHENSIVE MENTAL RETARDATION PLAN

December 1965

39] *Away from Custodial Care*

Fewer than two percent of the residents of Pennsylvania's state schools leave the rolls each year; and half of those by death, rather than by discharge. A discharge rate of less than one percent has two implications: First, that beds are not opening up for persons in the community who need them; and second, that the state institutions continue to provide a program that barely rises above purely custodial care, if it rises at all.

The low discharge rate is partly due to factors external to the schools. It has proved highly difficult to find a place in the community for persons who need protection, and who must compete for scarce jobs with intellectually more gifted individuals. Only limited action can be taken to correct such problems, e.g., establishment of urban "halfway houses" for vocationally trained youngsters.

But vigorous steps can and should be taken to provide programs within the state schools that will help residents develop to the limit of their capacity as human beings. These programs will require strong state financial support, during the transition from traditional custodial care.

Diagnosis and evaluation has been provided in Pennsylvania, as elsewhere, primarily in academic or independent centers oriented to professional training and clinical demonstration. The exceptions have been three state-supported diagnostic and evaluation centers for the mentally ill and mentally retarded which, as screening agencies for applicants to the state schools, have served a fraction of the retarded population.

The time has come to develop diagnostic and evaluation centers to provide services corresponding to needs. A more pressing need appears to be the need in the diagnosis of the severely retarded and infant retardates to permit correct diagnosis and early treatment. The state schools can have a major role in such services.

They are situated in largely rural areas, remote from the urban centers where services are more plentiful. (And, uniquely in their areas, they have or should and will have) staff representing the entire range of professional skills needed for diagnosis and evaluation.

The state schools, therefore, should be considered as prime locations for diagnostic and evaluation services. Moreover, they are logical "home bases" for traveling professional teams set up to carry on diagnosis and evaluation in more remote communities, and to train professional and community leaders there to recognize signs of possible mental retardation.

Within the state schools there is pressing need for systematic *to evaluation* programs. Too many residents have entered the schools and become lost inside, in effect, going for years at a time without re-examination. This is borne out by the fact that 2% of the residents in state schools do not have a level of retardation reported

and 1% of the residents in state schools are reported as having no retardation.

Many of the institutions are establishing yearly re-examinations. Even this may not suffice for youngsters who "grow" rapidly in training or educational programs.

State schools should consider providing *short term residential* care for three different purposes.

First, short term care should be available with diagnostic and evaluation services. Some individuals need observation over a longer period of time to be adequately evaluated.

[10] Second, short term admission should be available for "parent relief", to help families of retarded individuals over family crises or to allow parents a needed vacation from the 24-hour care of a retarded child.

Finally, short term admission should be available to retarded individuals who can profit from brief periods of intensive services; for example, a rural child who might be unable to attend regular speech clinics, but who could profit from several weeks of daily speech therapy.

To provide short term care, the state schools need revised statutory regulations covering their admissions.

If the *long term focus* in the institutions is to be replaced by short term focus, including parent relief, the effect of this will be longer waiting periods for admission unless discharge rates are shortly increased or facilities for schools are markedly expanded.

The state schools should study a plan being tested in Missouri in which parents are asked for reasons why they need to place their child. The state then tackles the needs from both ends; by seeking to habilitate the child, and by arranging to have social services applied to family problems. If and when the reason for placement is removed, the child is returned to his home.

In the program, long term care serves a function similar to that of "emergency" short term care, but extended over more time; that is, to help the family over a crisis that is preventing it from providing for the retarded child.

A946

PARC Ex. 21

THE 1969 and 1979 PENNSYLVANIA STATE PLAN FOR THE CONSTRUCTION OF FACILITIES FOR THE MENTALLY RETARDED

Volume I

Department of Public Welfare
Mental Health and Mental Retardation
Division of Planning, Evaluation,
and Community Programs

[11] III. *Program Goals and Objectives*

Comprehensive planning for the mentally retarded in Pennsylvania is based upon the principle that all programs should increase the opportunity for each retarded individual to attain his fullest potential. It is clearly recognized that a comprehensive and diversified program of community based services accessible to the retarded and their families is the basic goal underlying the Commonwealth's planning effort. Such community programs would include preventive services; diagnostic clinics; nursery classes for pre-schoolers; parent education and guidance; recreation; vocational training and sheltered work experience; job placement and follow-up; halfway houses; group homes and short-stay provisions, as well as other types of community care for the retarded. Maximum utilization and coordination of general community health and welfare services is recognized as of primary importance.

The Commonwealth's planning program, therefore, conceives of program and service development in terms of both specialized and general services. Based upon the problems and needs of the regions and administrative units herein defined, the Commonwealth of Pennsylvania accepts responsibility for providing leadership and

the allocation of resources toward the development of essential community services for all ages of retarded and levels of retardation through the establishment of both special and general services.

In addition, it is also a firmly established goal that those retarded individuals in need of residential care away from home will have available to them the best quality of care, which, when possible, will be directed toward rendering such individuals capable of community living.

The development of necessary services and facilities for the retarded in Pennsylvania will be based upon a thorough knowledge of the extent of mental retardation and related resources. Based upon a planning program which has evaluated current and future needs, the Commonwealth of Pennsylvania will make a concerted effort to combat mental retardation through a programmed development of resources for this purpose.

The Construction Plan for Mental Retardation Facilities will serve as a basis for allocation of Federal funds available under Title I, Part C., P.L. 88-164. Construction priorities will reflect current needs and will serve as a guideline for the establishment of effective services for the diagnosis, treatment and care of the mentally retarded.

* * *

A948

PARC Ex. 25

April 12, 1972

Proposed Expenditure of All Capital Funds for Pennhurst — Supplement (Questions raised regarding the proposed total dispersal of that institution by the end of fiscal year 1974-75)

William B. Beach, Jr., M.D.
Deputy Secretary for Mental Health and Mental Retardation

Edward R. Goldman
Commissioner of Mental Retardation

1. What is being done to spend the Act 256, G.S.A. 523-1 funds authorized for logical dispersal and reorientation into the community of 900 Pennhurst residents:

Phase I of this project has already been completed. The scope of Phase I was to determine the type, size, and recommended location of community facilities required to provide definitive treatment and normalizing accommodations for approximately 000 persons currently in residence at Pennhurst. To accomplish Phase I, a project director and staff of eight persons were employed for six months to conduct a demographic study and social systems analysis of the institution and the five counties served by it. The results (Region I Planning Project, attached) have been distributed for review and accepted by the five concerned County Mental Health and Mental Retardation Program Offices. Approximately one year ago, the Southeast Regional Office was requested to secure written acknowledgment of this acceptance by January 30, 1972 so that G.S.A. might proceed to acquire and construct/renovate the necessary facilities. G.S.A. has already ap-

pointed the architects and the Regional Mental Health and Mental Retardation Director is currently scheduling meetings with each concerned County Office of Mental Health and Mental Retardation to secure the necessary written authorizations.

We understand G.S.A. can proceed immediately with the design and construction phases once this authorization is received from the Department. It might expedite matters if the Department could reinforce the already expressed need for immediate Regional attention and follow-through.

2. Timetable to spend the funds:

Act 256 stipulated that the project was to be completed as expeditiously as possible so that the first units might be occupied not later than two years from the effective date of the Act (by November, 1972). Although Phase II of the project has been unfortunately delayed, there is no danger that the funds will be lost. The Department's legal office has advised us that this stipulation is directory in nature, not mandatory. (Time Limit on G.S.A. Funds for Dispersal of Pennhurst, attached). It is reasonable to expect that, since the units in question are not the large traditional institution-type facilities and that four architects have been appointed to ensure that Phase II might proceed simultaneously across the region, the project should be completed by the end of fiscal year 1974-75. A more specific timetable will be contingent upon the capacity of G.S.A. to honor the directory stipulation "as expeditiously as possible" and the Department might do well to remind G.S.A. of the urgency of this project when it forwards the written authorizations to proceed.

[2]

3. What steps must be taken to spend the funds:

A. The County Mental Health and Mental Re-

tardation Program Office's written submission of approval must contain a finalized listing of the specific types of units appropriate for each County in terms of each County's developing program plan for a continuum of mental retardation services, and at least the approximate geographic location for each type of unit to be renovated/constructed.

B. Once secured, the above information must be forwarded to G.S.A. with a request by the Department for all due haste in follow-through.

C. It has already been recommended by this office that G.S.A. be requested to appoint an *on-site* special coordinating architect for the Southeast Region to expedite the follow-through and to synchronize the simultaneous activation of construction/renovation in five counties. We have been assured by a consultant architect that by coordinating the design phase, sharing design and construction information and materials and "riding herd" on the process to eliminate unnecessary hang-ups and waste of time, the Commonwealth could save both time and money. Although this request was not considered feasible by our management office and the G.S.A. when originally made, we suggest that it be reiterated with the submission for the Department's authorization to proceed.

4. What is the County's role in the program to be provided in the facilities and in their planning:

These units are to become a permanent and integral part of each County Program's planned continuum of mental retardation services and the County Program, through its Base Service Unit mechanism, is responsible to:

A. Assess the condition and circumstances of each Pennhurst resident prior to his proposed relocation;

B. Prepare individual life-management plans for each person to be so placed, including a definition of the special purpose to be served by the placement;

C. Establish an individually appropriate and realistic personal development goal to be accomplished for each person by each such placement;

D. Maintain regular liaison with the unit to ensure:

[3] (1) that time spent in residence is limited to the time required to accomplish the established goal; and,

(2) that service provided by the facility is consistently more suitable than the person might receive elsewhere in the community.

E. Establish a counseling/planning relationship with each unit, each resident's family, and the resident himself when possible to expedite the achievement of optimum independence for each resident;

F. Prepare post-release service plans and develop County Program post-release services and resources as indicated for each resident; and

G. Assume fixed follow-along responsibility for each resident and his family as required.

In keeping with its responsibilities to the persons being served by these units, the County Program Office will perforce be the determiner of each unit's service role and the coordinator of each unit's function as a unit of service which is to be part of a continuum of community-based units of service, which all together will constitute the "program." The residential unit is not in itself

to be considered a program; it's to be a structured living arrangement, not a small total institution geographically located in the community. In order to integrate these residential units socially as well as physically into the community as mandated, the County Program must simultaneously expand existing and develop new non-residential community services to meet the educational, training, recreation, and work requirements of each resident as his capacity for self-care, self-sufficiency, and self-support increases.

5. Where in the County will the facilities be located:

Each unit must be located where its residents will secure optimum benefit from non-residential community services and resources and in keeping with each County Program's plan to develop a comprehensive mental retardation service system. The Region I Planning Project study provides suggested locations based on a social systems analysis of each County's current resources. The County Program has an option either to adopt these location suggestions or to revise them more in keeping with its own planning projections and the realities of its local situation.

6. What programs will be carried out in these facilities:

See answer to Question 4. It is expected that each unit will provide program in keeping with the service objectives and requirements of the residents it currently serves. As the residents develop greater competence and their needs change, the program should also develop and change. As the social competence of each resident increases to the degree that he can return to his own home or move to another less structured living environment, the unit's program should be updated in terms of the replace-

ment residents referred to it. A rule of thumb for programming is the more sheltered the environment, the more structured the program. Less competent persons require more intensive and more continuous training and education. No referral to a residential unit should be considered a dead end, even if the placement is for an indeterminate length of time.

[4] 7. Where will operating funds come from:

The existing Pennhurst operating budget can be deployed into the operation budgets of the new units:

A. Units that are primarily for persons who require health care and medically-supervised personal care more than any other service will be constructed/renovated to meet Federal skilled nursing home and/or intermediate care requirements. Operating funds for these units will be a combination of Federal MA and State funds.

B. All other type units will require State operating money to the degree that we cannot secure 75-25 federal social service reimbursements. It is anticipated that as a minimum, we will be able to secure such reimbursement for all services provided on these premises except for food and maintenance.

8. Construction Timetable, completion and occupancy:

As already discussed under questions 2 and 3, the details of the construction timetable are contingent upon G.S.A. capacity to follow-through after authorization. They are also contingent upon County Program decisions, whether to construct or renovate. It is recommended that, as much as possi-

ble, existing structures be utilized. They are more normalizing and can be more quicky readied for occupancy than new construction. They should also be less expensive and can be readily abandoned and sold, should the population base change and their program useability deteriorate. Despite our inability to pre-determine the specifics of the construction timetable at this time, completion and occupancy should reasonably be expected by the end of fiscal year 1974-75.

9. Implementation of dispersal with timetable:

The Department should request a construction/renovation timetable from the architects with its submission of the authorization to proceed. When this is available, it will then be possible to chart the implementation of the dispersal with a timetable.

10. Who will be selected to return from the institutions — first and thereafter. Who will make the selection and what will be the role of the County Program:

In this instance, to expedite a long overdue resolution of the hazardously overcrowded Pennhurst situation, the institutional staff, in conjunction with Planning Project staff, conducted a demographic study of the institution's population and made the selections, in keeping with a concommitant Project team analysis of the potential of each County's social service system to support the dispersal process. In the future, County Program staff, Institutional staff, consumer representatives, providers of community services, representatives of public and private resource agencies, families of residents and retarded persons themselves should all participate in the selection of persons to be reoriented into the community. In the future, the Regional Office should be responsible to coordinate this selection

and planning process and the County Program must be given decision-making authority commensurate to its delegated responsibilities.

[5] H. If Pennhurst is phased out:

a. how will all services (support) for a large institution be geared to one building;

b. what will happen to all present employees; and,

c. what will happen to land and buildings.

a. Assuming that it can be justified as sensible to keep, the new building in use as a residential service after the proposed total dispersal, previous engineering evaluation of the Pennhurst support services seems to indicate that: (Proposal for Renovation of Utilities, Pennhurst State School and Hospital, January, 1971.)

1. The existing, outmoded, deteriorated and uneconomic boiler plant could be abandoned and a small packaged oiler boiler unit with gas standby added to serve the single building. This would provide adequately for heating and air conditioning at a roughly estimated cost of $250,000.

2. The existing electric substation and wiring as it stands is adequate to serve the new building with its reduced population (168) with no further capital investment. An option would be to have Pennsylvania Electric install a new substation to serve the new building and abandon the existing one. Estimates can be secured to determine which is the more economical alternative for the Commonwealth.

3. Since water as currently supplied from the three remaining operative wells out of an original number of eight is considered inad-

equate, non-potable and undependable, it would be more economical to abandon the remaining wells and purchase water from the local community.

4. Dietary facilities as they stand are adequate to serve the reduced population (168) of the new building.

5. The inefficient, outmoded, deteriorated laundry culd be abandoned at a savings. It would be more economical to purchase commercial laundry service for 168 people than to renovate, reequip, and staff the existing utility.

6. When the necessary installation ($50,000) of a lift station now in process, is complete (pollution citation because of the dairy complex) the existing sewage facilities will be adequate for the reduced population of the one remaining building until such time as the new building can be hooked into community sewage disposal as planned. This would ultimately be more economical.

In general, it seems that the deteriorated, outmoded and wasteful operating condition of the majority of the Pennhurst support services eliminates the possibility of there being any problems connected with gearing these utilities into service to the reduced population of the single building, assuming that continued use of this building can be substantiated.

[6] b. The majority of Pennhurst's existing professional and direct service staff (approximately 900 persons) could be absorbed by Embreeville and by the projected residential units to be established in the communities (particularly by Health Care Facility types I and II). Placement of the remaining support service staff (approximately 600 persons)

would probably require systematic, planned intensive placement and job development efforts on the part of the Department. The problem of relocating the 1,511 person Pennhurst fixed staff complement might also find a solution in the retraining and job possibilities inherent in the pending takeover of Pennhurst's farm by the Department of Agriculture in 1973.

c. The Department of Agriculture is currently developing long overdue innovative new directions for enriching health, social, recreation and employment opportunities for Pennsylvania's rural population. The Pennhurst campus might prove to have valuable potential for future use as a rural resource development site. The farm, modernized, properly equipped, adequately staffed, and efficiently managed, could be a nucleus around which improved and new uses for rural land might be explored and new rural careers and manpower development programs developed. The Department of Agriculture is concerned to improve the life style and living conditions of the same citizens who are the primary concern of this Department. It is recommended that this Department and the Department of Agriculture together begin planning now for a combined approach to a new constructive career for Pennhurst.

A958

April 7, 1972

SUBJECT Proposed Expenditure of All Capital Funds for Pennhurst

TO William B. Beach, Jr., M.D.
Deputy Secretary for Mental Health and Mental Retardation

FROM Edward R. Goldman
Commissioner of Mental Retardation

The various available and projected capital investments for Pennhurst total $38,094,000 through fiscal year 1973-74. (Various Available and Projected Capital Investments for Pennhurst attached) A pending request to amend Act 256 by consolidating renovation Projects Female 1; $2,300,000; Female II, $2,300,000; and Utilities, $2,678,000 will add $822,000 to this total if honored. The total proposed investment is therefore $38,916,000; $21,079,000 to be invested in the community to serve 959 persons (Act 256 Pennhurst Dispersal Projections attached), and $17,837,000 for minimal on-site renovations intended to protect the lives and improve conditions for Pennhurst residents during and after the pending reduction in population from 1,799 to a maximum allowable census of 760.

Recent events now invalidate the proposed on-site investment of $17,837,000 and it is necessary to update this proposed expenditure in terms of Chapter 34 requirements; the Department's recent (December, 1971) architectural reassessment of Pennhurst's physical capability to meet basic skilled nursing home criteria; and the recently acquired option to transfer 600 Pennhurst residents to Embreeville by the end of fiscal year 1972-73. It would be fiscally irresponsible for this program office to permit the Department to proceed with these on-site projects as proposed without such a reassessment.

Today, after 69 years of existence and capital investments totalling $25,289,854 (Capital Assets Ledger List-

ing and Summary of Completed Renovation and Construction Projects attached), Pennhurst is apparently a total loss to the Commonwealth as a mental retardation service resource. All of its buildings, including the brand new $6,427,371 Hyperactive Children's Building, violate minimal health, social and safety standards and are totally unsuitable for modern mental retardation program purposes. It cannot earn a single dollar in Federal Medical Assistance benefits and its maximum allowable census has recently been reduced *to 616 residents* after required renovation costs of $13,733,980 although it currently houses more than 1,600 persons. (Pennhurst — Current Maximum Allowable Census, etc., attached)

[2] Renovation costs to existing resident housing have escalated in direct proportion to the Chapter 34 requirements, and the reduced maximum Allowable Census ratings of our basic skilled nursing home criteria. In addition to the $13,733,980 now required for resident housing another sum of $8,069,542 is considered necessary to upgrade support and program facilities. (Plan B, Master Facilities Plans A, B & C, Pennhurst State School and Hospital, prepared by Bureau of Construction and Maintenance, July, 1971) This total sum of $21,803,522 is $3,966,522 greater than the on-site capital renovation investments of $17,837,000 originally proposed as minimally required to protect the lives and improve conditions for Pennhurst residents during and after the pending reduction in population from 1,799 to a Maximum Allowable Census which has now been reduced to 615 persons, thus increasing the cost per person per bed to $35,452 from $23,469+.

It is clear that we can no longer afford the luxury to spend what has to be spent to assure minimum safety and convenience for Pennhurst residents during the length of time required for the County Programs to gear and tool themselves up to support a systematic phased redirection of capital resources into optimum use con-

sistent with the Department's humane commitment to reverse Pennsylvania's mental retardation service system from its institutional base to one based in the communities. It is obvious that the capital investment now required on-site at Pennhurst violates this office's Principles and Policies for Renovation and Construction at State Schools and Hospitals. (Principles & Policies Statement attached) The new renovation cost of $21,803,522 is far greater than the functional worth of Pennhurst's existing buildings after such renovation; in fact it is $2,827,356 in excess of the $18,976,166 estimated as the cost of rebuilding the institution. (Plan C, Master Facilities Plans A, B and C, Bureau of C & M, July, 1971)

The truth of the matter is that while it might be less expensive to construct new buildings at Pennhurst than it would be to renovate existing buildings; both options are prohibitively expensive in comparison with the option for logical dispersal into the community and cannot, therefore, be justified in terms of either an economical 50 year fiscal commitment for the Commonwealth or as being in the best interests of those to be served. (See Act 256 Dispersal Proposal Projection attached)

[3]

Proposed Cost Per Person On-Site Prior to Reduction of Maximum Allowable Census of Existing Resident Housing	$23,469+
Proposed Cost Per Person On-Site After Reduction of Maximum Allowable Census and Required Additional Renovation (Plan B)	$35,452+
Proposed Cost Per Person On-Site After New Construction of Resident Housing (Plan C) . .	$29,284+
Proposed Cost Per Person, Community Dispersal Project .	$21,980+

Fortunately the recent activities of the Department's new Capital Facilities Planning Committee provide us a new, more viable, more economical and potentially more human option for accelerating the Pennhurst dispersal process. It was determined on March 27, 1972, by the Committee that it was realistic to project the transfer of from 560 to 800 Pennhurst residents to Embreeville during fiscal year 1972-73. Subsequently it was further determined by engineering staff from Pennhurst and Southeast Region that approximately $1,519,500 would be required for specific renovations (exclusive of air conditioning) necessary to meet appropriate safety, health, social and program standards for the first 560 persons to be so moved.

The Embreeville Transfer option is of course a compromise. It would be foolish to consider this stop-gap phasing of Pennhurst residents into 12 year old hospital buildings designed to provide custodial care for mental patients as anything but a temporary measure forced upon us by the emergencies of an obsolete, deteriorated and overcrowded State School and Hospital system. To do so would violate OMR Principles and Policies to the same degree that Pennsylvania's existing mental retardation institutions violate these principles and policies. However it is a compromise that could be acceptable and one the Department might implement without losing credibility if it is made clearly subject to the constraints implicit in OMR Principles and Policies and with a guaranteed time limit placed on the continuing use of Embreeville consonant with a rigorous Departmental enforcement of County Program responsibility to develop and establish adequate and appropriate residential and non residential community alternatives to institutionalization for mentally retarded persons and their families. If properly controlled, the use of Embreeville to augment the Act 256 Dispersal Project could provide:

1. immediate relief to Pennhurst residents from the serious safety, health and social hazards endemic in that institution;

2. a savings to the Commonwealth of $17,398,000 currently proposed for further capital investment in an obsolete functionally worthless uneconomical State School and Hospital; and

3. an acceptable temporary transitional phase from old warehousing patterns of institutional care to normalizing accommodations in the community.

4. a total phase-out of Pennhurst during fiscal year 1974-75. (If the Embreeville Option is Exercised, attached)

[4] Best of all, if the use of this transfer option succeeds for Pennhurst and the Southeast Region it can open the door for logical State-wide dispersal and reorientation into the communities of all State School and Hospital residents in excess of the population any given institution can properly care and program for under the constraints imposed by OMR Principles and Policies for Capital Investments In State Schools and Hospitals.

This office, therefore, recommends that the Department exercise its authority to implement the Embreeville Transfer option as rapidly as possible; but only under the following conditions to ensure that:

1. There shall be strict adherence to OMR Principles and Policies for Capital Renovation and Construction;

2. There shall be strict adherence to the National Association for Retarded Children Policy Statement on Mixing of the Mentally Ill and the Mentally Retarded (pages 10 and 11, Policy Statements on Residential Care Adopted by the Board of Directors of the NARC, October, 1968, attached)

3. The mentally retarded residents of Embreeville shall reside in a separate and discrete unit(s), shall be provided with separate and distinct programs and shall be under the direction of a separate

administrative head ultimately responsible to the Commissioner of Mental Retardation through the Southeast Regional Office. He shall have such experience and training as is appropriate to supervise and direct a developmental residential service for mentally retarded persons.

4. The appropriate Base Service Unit shall be notified regarding each person transferred to Embreeville from Pennhurst and there shall be strict adherence to the provisions of 5200 Appendix IV regarding the functions of the Base Service Unit in regard to persons in residence in facilities. The Aftercare Services as defined in Appendix IV shall be provided in collaboration with the individual's family, the Embreeville staff and the person himself when possible.

5. The 5 Southeast County Program Offices shall develop and include as part of their Annual Program Plan and Budget Submission plans for the further dispersal of those persons temporarily placed in residence at Embreeville within a reasonable amount of time.

6. There shall be regional participation in the planning and implementation of the Embreeville Transfer option as defined in OMR Principles and Policies.

[5] Further, pending final acceptance of the foregoing recommendation and conditions, this office herewith requests that all the various available and proposed renovation and/or construction projects for Pennhurst be cancelled with the exception of the following:

$21,079,000 —	Act 256 —	Dispersal Project
$ 387,500 —	Act 256 —	Air Condition Hyperactive Children's Building (this project is retained since the Hyperactive Building is the newest structure on the Pennhurst Campus will undoubtedly be the last to be abandoned. It might be prudent to retain this building in as useable a condition as possible to provide back up placement for 168 persons beyond the projected 1974-75 phaseout date in the event of emergencies or special problems.
$ 50,000 —		Property and Supplies for 1971-72 — Install lift station forced main from dairy complex to sewage disposal (this is required — citation for pollution)
$ 53,000 —		Regional Jobs (These are relatively small emergency repairs required for day to day operations)
		Replace roof and flashing.
		Boys' Vision Unit 11,000
		Girls' Vision Unit 11,000
		Repair Roof, Building G (Dietary) ... 3,000
		Repair build up roof (?) 6,000
		Provide toilet facilities, Penn-Hall Grove 6,000
		Repair Penn-Hall roof 8,000
		Renovate condensate return system, Building 5 8,000
$21,569,500		

It is also recommended should the Embreeville option be implemented, that sufficient capital funds be added to the estimate of $1,519,500 required for renovation at Embreeville to provide air conditioning as indicated to further protect the health and well-being of the transferees.

Approximately one year ago today, on April 19 and 20, 1971, this office's Principles and Policies for Renovation and Construction at State Schools and Hospitals were formulated during an Architectural/Program Review convened by this department in collaboration with the Pennsylvania Association for Retarded Children. Gunnar Dybwad, Professor of Human Development, Florence Heller School, Brandeis University; and George V. Gray, Director, Mental Hygiene Facilities Planning, New York Department of Mental Hygiene provided consultant services during this review at the

Department's request and in keeping with the Administration's new commitment to eliminate existing institutional health, safety, and social hazards as quickly as possible and ultimately to insure for every retarded citizen of the Commonwealth his right to live a life as close as possible to that which is typical for ordinary citizens; in his own home or as close to his own home as can be arranged.

[6]

Today, it seems even more relevant than a year ago to posit:

> "The Pennhurst dilemma is the dilemma of all the State Schools and Hospitals. Pennsylvania is at a turning point in its delivery of services to mentally retarded persons but there is as yet: no official redefinition of the State School and Hospital role; no systematic master-plan to coordinate the development of County Programs with projected plans for the institutions; and no guidelines established to redirect available resources into optimum use consistent with the new emphasis that centers on the community as the mandated program base for all mental retardation services. The enlightened authorization of Act 256 (unique in the nation) for investment of more than $21,000,000 in construction in the communities to reduce the overcrowding at Pennhurst by 900 residents, highlights this dilemma and focuses in on Pennhurst as the pivotal starting point for statewide reversal of the traditional institutional role." (Mental Retardation Summary Report State Schools and Hospitals, Architectural/Program Review — 4/19/71-4/20/71.)

OFFICE OF MENTAL RETARDATION — PRINCIPLES AND POLICIES: CAPITAL RENOVATION AND CONSTRUCTION INVESTMENTS

I

Principle:

"The mentally retarded person has a right to live with his own family or with foster parents; to participate in all aspects of community life and to be provided with appropriate leisure time activities. If care in an institution becomes necessary, it should be in surroundings and under circumstances as close to normal living as possible." (Declaration of General and Special Rights of the Mentally Retarded: International League of Societies for the Mentally Handicapped.)

Policy:

No further capital funds shall be invested in new construction on old isolated State School and Hospital sites unless it is verified by professional architectural/engineering and program assessment, that this additional 50-year investment in the life expectancy of the institution is an economical commitment for the Commonwealth; will not encourage unnecessary and prolonged institutionalization, and does not deprive mentally retarded citizens of their right to be served in their own communities.

II

Principle:

"The primary purpose of a residential facility is to protect and nurture the dignity, health and development of each individual requiring twenty-four hour programming services. Inherent to this commitment is the responsibility to provide those experiences that will enable the individual to: (1) develop

his physical, intellectual, social, and emotional capacities to the fullest extent; (2) live in an environment that is conducive to personal dignity while in a residential setting; and (3) continue development of those skills, habits, and attitudes essential to adaptation in contemporary society." (Standards for Residential Facilities for the Mentally Retarded: Joint Commission on Accreditation of Hospitals; Accreditation Council for Facilities for the Mentallyi Retarded.)

Policy:

A professional architectural/engineering and program assessment shall be made of the structural and functional capabilities and requirements of all institutional structures requiring renovation and a determination reached regarding whether or not the proposed expenditure is economical prior to any decision to proceed with said renovation. If the functional worth of the building, after being renovated, is less than the money to be spent in order to do this renovation, the proposed renovation is uneconomical. A maximum allowable census shall then be ascertained for each State School and Hospital based on the reality of each institution's structural and functional capabilities to house and program for its residents appropriately, safely, and economically.

III

Principle:

"The facility should be located within, and conveniently accessible to the population served, so as to have access to necessary generic community services. The facility should not be isolated from society or community by factors such as: difficulty of access due to distance or lack of public transportation; architectural features; socio-cultural or psychological

features; rules, regulations, customs, and habits." (Standards for Residential Facilities for the Mentally Retarded; JCAH.)

Policy:

All future capital investments in facilities to house State School and Hospital residence in excess of the population any given institution can properly care and program for under the constraints implicit in policies I and II above shall be: dispersed into the communities; be under the direction of the County Mental Health/Mental Retardation Program, and shall be small, differentiated, homelike living arrangements in accord with the principles of normalization and in keeping with the Department's commitment to revise the State's mental retardation service system from its institutional base to one based in the community.

IV

Principle:

"The local authorities of each county . . . shall establish a county mental health and mental retardation program for the prevention of mental disability and for the diagnosis, treatment, care, rehabilitation or detention of the mentally disabled. . . . (Mental Helath/Mental Retardation Act of 1966, Article III, Section 301 [a]).

Policy:

The role of each State School and Hospital shall be redefined as follows in keeping with the foregoing principles and policies: A state operated residential service which is only part of residential services which are part of a continuum of community services which the County Mental Helath/Mental Retardation Program is mandated to develop, direct, and deliver in associated coordination for mentally retarded persons and their families.

V

Principle:

"The Department shall have power, and its duty shall be . . . To establish and maintain working relationships with other government bodies and public and private agencies, institutions and organizations so as to assure maximum utilization of services and facilities which each such government body and public and private agency, institution, and organization may have, which may be of benefit to the mentally disabled." (MH/MR Act of 1966, Article II, Section 201 [5].

Policy:

All relevant governmental bodies and public and private agencies, institutions and organizations shall participate in planning, review and final decision making for all future capital renovation and/or construction projects proposed either for institutional sites or for dispersal into the community: including but not limited to County Administrators, Consumers, Consumer Advocate Groups, Regional.

Pennhurst — Current Maximum Allowable Census and Required Renovation Cost

(DPW: Medical Service Office Architectural Survey — December, 1971, and Bureau of C & M, Plan B, Master Facilities Survey Plans A, B & C, Pennhurst State School & Hospital July 1971)

Building	Rated Capacity	Resident Housing Required Renovation Cost
I	64	1,841,000
II	64	1,663,200
III	96	2,359,600
IV	60	3,162,760
V	23	314,160
Penn Hall	40	898,380
Continuing Care	32	1,142,400
M	28	1,123,200
Q	16	608,220
Hospital	24	306,900
New Building	168	314,160
	615	13,733,980

(All other buildings are considered unsuitable for continued occupancy. Under no circumstances, regardless of further investment, the new building cannot be redesigned into compliance with Federal skilled nursing home requirements.)

If the Embreeville Option is Exercised:

Pennhurst Resident Population, October, 1971 — 1,799
Pennhurst Reduction Projects to June 30, 1972 (in process)

Purchase of Community Nursing Care	100
1971-72 Special Living Arrangement Placements	200
Initial Transfers to Embreeville	20
Transfers to EPPI (emotionally disturbed)	16
1971-72 TOTAL REDUCTION	336

Projected Resident Population, June 30, 1972 — 1,463

Pennhurst Reduction Projects to June 30, 1973

Transfers, to Embreeville	600
1972-73 Special Living Arrangement Placements	200
New Southeastern State School & Hospital	150
1972-73 TOTAL REDUCTION	950

Projected Resident Population, June 30, 1973 — 513, or 102 less than the maximum allowable census.

Pennhurst Reduction Projects to June 30, 1975
Act 256, Dispersal Project — 959

Projected Resident Population — June 30, 1975 — minus 446

By 1974-75, it should be possible to completely phase out Pennhurst and have 446 community placements available either to reduce the Pennhurst waiting list or for further dispersal of those temporarily placed in residence at Embreeville.

PARC Ex. 26

PRESS CONFERENCE
MAIN CAPITOL BUILDING, GOVERNOR'S PRESS ROOM
THURSDAY, DECEMBER 14, 1972, 10:00 A.M.

Participants: Mrs. Helene Wohlgemuth, Secretary of Public Welfare
Mrs. Patricia Clapp, President, PARC

Questions from the press and answers from Secretary Wohlgemuth, assisted by Mrs. Clapp and Edward Goldman, Commissioner of Mental Retardation. Recorded and reproduced by Richard Parker.

Q. What is being done to prevent the group home from turning into an interim care facility?
A. An adequate level of care is being provided; personnel are being trained; supervision from the Base Service Unit is required; a monitoring system is functioning; arrangements with PARC through the Fellowship Plan so children are not lost in the system.
Q. How much will it cost to eliminate peonage?
A. This is being done in phases, but $1.5 million is in the budget.
Q. Where will you get the money if the Legislature refuses to give it to you?
A. I don't know, but it will be a real struggle.
*Q. If we are leading the nation in group homes, then cannot the money be used better somewhere else?
A. We are at a point in Pennsylvania with a program that is based in institutions. The cost of maintaining huge plants eats up dollars that should be used to care for people. We must start transferring institutional budget money into the community program. It is not good business to maintain these old warehouses.

*Q. Is it cheaper to house 1,000 mentally retarded people in 50 group homes than in one institution?
A. Absolutely — the institutional cost is four times as high as the group home. The cost in the institution ranges from $17.00 per day, per person to $35.00 per day. In the community home, the cost is approximately $8.00 per person, per day. This represents a very definite savings.
Q. Why then do we need the $12 million Deficiency Appropriation?
A. First, to reverse the processes of institutionalization requires money and time. Secondly, the recruitment and training of personnel. Then, thirdly, there is the cost of a monitoring system so we do not lose track of people.
*Q. If we do not get the $12 million, will be abandon the community home plan?
A. Positively not. We are committed to it and we owe it to the retarded.
*Q. Are you saying that all Pennsylvania institutions for the mentally retarded could be closed?
A. With the appropriate arrangement facilities, yes.
Q. How many people are being warehoused in state institutions?
A. 11,000 including those in the interim care facilities, with 5,000 on waiting lists for the institutions.
Q. What do the people do in a community residence?
A. Their lives parallel closely the lives of people in other homes on the street. They are encouraged to socialize. The purpose of the home is to normalize the life of the retarded. Life in an institutional setting dulls ones potential. There are approximately eight to twelve persons in a community home. We don't want to start building small institutions.
*Q. Won't the Legislature look at this $12 million request as welfare?

A. They may try to hide it under welfare, but the Legislature knows it is for the mentally retarded.
Q. How many staff members are required to a community home?
A. A set of full time house parents and a set of part time house parents who provide relief on the weekends. Also part time college and high school students who volunteer their services.
Q. In thirty communities where the homes are established, what is the reaction of the community?
A. Apprehension in the beginning, but once it is established, the people in the neighborhood get interested and often participate.
*Q. Will we see the day when all institutions in Pennsylvania will be closed?
A. Yes, we are going to close them all.
Q. Isn't it true the Right to Education is a financial responsibility of the Department of Education?
A. Yes, except for the children who are institutionalized.
*Q. Will there still be a need for the institution for the severely and profoundly retarded?
A. We must bring the severely retarded back to their own communities. We must try to place them in perhaps university hospitals or in other places where they will receive sophisticated professional care.

*Take special note of these questions.

COMMONWEALTH
of PENNSYLVANIA

The Governor's Review — 1975

WELFARE AND MENTAL HEALTH

[39] The mental health team, a total of 15 members, was responsible for surveying the operations of the Department of Public Welfare with particular emphasis given to the state's mental health and mental retardation institutions. In an effort to gain as much insight as possible, groups of two or three individuals spent the first five weeks of the study period visiting the various institutions and the department's four regional offices. Team members spent as much as two weeks at a single institution, reviewing its operations in detail. Later, they visited other facilities for one to three days. In all, 20 of the state's 31 mental institutions were covered. In order to achieve as broad a view as possible of the organization, operation and administration of individual facilities, team members also spent some evenings and weekends at the institutions and even participated in programs with patients/residents.

Visits were made to community-level mental health facilities throughout the state to gain a first-hand impression of possible alternatives to institutional care. In addition, operations of the County Boards of Assistance were reviewed. Following the field work, interviews were held with department personnel in Harrisburg to identify over-all objectives, operating methods and problem areas.

The department has been mandated through the Mental Health and Mental Retardation (MH/MR) Act of

1966 to develop an overall system of care which will make greater use of community-level mental health centers and thus decrease the number of persons committed to institutions. Implementaion of this objective has been very slow. Apparently, there are a number of factors contributing to this lack of effective action. A prime requirement — still unfulfilled — is the development of a comprehensive, long-range plan with specific objectives. Interference from unions, special advocacy groups and local civic and political organizations has been another impeding factor. Strong, determined leadership is needed to move the department ahead to carry out its objectives despite existing opposition.

Although the deprtment lacks a comprehensive program, a tremendous amount of planning is done. However, it is fragmentary, uncoordinated and, for the most part, unimplemented. For example, regionalization of the department's administrative functions has been implemented in part, but there has been no delineation of responsibilities or appropriate delegation of authority. As a result, there is confusion, inadequate accountability, responsibility gaps and a duplication of work between the central office and the regions. All contribute to reduced effectiveness and higher costs. A number of crganizational and operational problems also exist within the County Boards of Assistance.

A recommendation has been submitted which mandates a comprehensive plan oriented toward the concurrent build-up of community MH/MR programs, together with a consolidation of institutions into more cost-effective operations as balanced components of a good complete, overall mental health care system. The depersonalization of individuals in antiquated and inappropriate buildings at the institutions is very apparent. The observed results of moving these people to community-sponsored facilities mandate the aggressive development of more of these programs under county sponsorship. Individual recommendations to support

and augment the comprehensive plan relate to the closing or phasing down of institutions, the provision of monetary incentives to the private sector, the movement of state employees to community programs and the allocation of an appropriate funding stream for accomplishing all this. It is important that the state realize not all groups can be satisfied, and that some must be temporarily inconvenienced for the long-term good of the majority.

A new organizational structure for Department of Public Welfare has been proposed which will strengthen the regionalization concept, and make it a more effective system for managing the state's institutions, programs and functions.

Several recommendations deal with methods to improve the functions of the County Boards of Assistance. These include computerization of files and assigning direct control of all activities to the regional commissioners, Income Maintenance. In addition, it is recommended that the number of board offices in the state be reduced.

In evaluating these recommendations, it is important that those responsible for implementation focus more on the broad, overall methodologies presented, rather than on some of the details included in the write-ups.

As a result of the team's involvement with the mental health program, some of the recommendations presented may go beyond the clear limits of management and administration and cross into the gray area of program and mental health science. This has not been done in an accidental or haphazard manner, but with close coordination and counsel from knowledgeable persons within the department.

Despite the problems which were identified, the team members were impressed by the professionalism and dedication of the employees they contacted in the Department of Public Welfare. In many cases, outside

pressures have prevented them from fully realizing
[0] wortwhile goals in regard to the state's mental health and mental retardation institutions. Concentrated planning, effective guidance and dynamic leadership are needed to enable the department to overcome these pressures.

* * *

STATE MENTAL HEALTH AND MENTAL RETARDATION INSTITUTIONS

[52] The Department of Public Welfare operates 20 state hospitals for the mentally ill and 11 schools and hospitals for the mentally retarded. The Mental Health/Mental Retardation (MH/MR) budget for fiscal 1975 was $405-million. Of this amount, $287-million was state funds. During the past 10 years, institutional populations have decreased from about 48,000 to 26,000. This is in line with the trend toward deinstitutionalization initiated by the 1966 Mental Health/Mental Retardation Act. It authorized establishment of a wide range of services for the mentally disabled at the community level. Staff levels, however, have increased during the period from 20,400 to 25,500.

RECOMMENDATIONS

147. Develop a comprehensive MH/MR plan which specifies facility consolidations within the service framework mandated by the MH/MR Act.

Under the MH/MR Act of 1966, the state is committed to developing — in cooperation with its communities — a mental health and mental retardation care system which provides a total spectrum of services. However, there have been many delays in the actual realization of this system. A major roadblock has been the disproportionate flow or human and dollar resources into the institutional component of available service facilities. As an example, the fiscal 1975 appropriation provided $403-

million for MH/MR institutions while furnishing only $83-million for county-operated programs and services.

Proposed Approach: The department secretary should assign top priority to the development of a concise plan to specify cost effective consolidation and utilization of state-operated institutions. It should be consistent with the framework established by the MH/MR Act of 1966 and contribute to the state's program to provide a total spectrum of adequate services at an affordable price. The proposed plan should include the following objectives:

- Consolidate MH/MR operations with the best physical and program resources.
- Achieve full utilization of necessary institutions.
- Phase out and dispose of obsolete and marginal facilities promptly.
- Develop a common funding stream for state and community programs and apply a substantial portion of the resources saved in institutional consolidations to the development of community programs.
- Budget to meet long-range program objectives based on a total project life cycle.
- Develop a program to facilitate transfer of trained institutional personnel into county programs.
- Establish an appropriate statewide balance between the geographic distribution of persons requiring services and the programs, facilities and services available to meet those needs.

A component plan should be developed for each of the department's four administrative regions. The components should define all the necessary decisions to be made and the steps to be taken in accomplishing specific regional objectives. Major benefits will be realized in

terms of improved care and treatment for those individuals who require MH/MR services. Development of alternative types and levels of service and care at the community level should substantially reduce the requirements for long-term confinements and, as a result, could lower the institutional population dramatically. Some 18 of the recommendations which follow represent integral parts of the proposed comprehensive program. Specific savings have been included with the individual recommendations. The overall amount is estimated at more than $30-million annually with a one-time benefit of almost $90-million.

Implementation Strategy: The successful implementation of a comprehensive MH/MR system will depend on the development of a master plan. It must clearly define feasible consolidations, tasks to be performed and schedules to be met. Accurate cost estimates and budgets must also be provided. The secretary, Department of Public Welfare, should have a master plan completed within three months.

* * *

[55] **155. Close all of the obsolete and unneeded MH/MR institutions.**

Many of the state's MH/MR institutions were built more than 50 years ago when the philosophy of patient care was different from what it is today. In some cases, residence buildings will require extensive and costly changes to meet standards established by the Life Safety Code. Even with renovations, the majority of the structures will still not be suited to modern rehabilitative programs. However, a continuing trend toward deinstitutionalization and development of more community programs have caused underutilization of facilities in more modern institutions. While the Department of Public Welfare has taken some steps to phase out obso-

lete institutions in favor of improved utilization of newer ones, various pressures from union and community groups have halted progress toward this objective.

Proposed Approach: A comprehensive plan to redistribute MH/MR patients has been suggested in another recommendation. As part of this program, some of the institutions which would require extensive renovation should be closed. This should be done under a coordinated approach as other institutional and community facilities are made available. In addition to the three institutions identified for closing in other proposals, at least three others should be closed. Possibilities might be Dixmont, Cresson and Hamburg.

Implementation would provide an annual saving of approximately $6-million in state and $6.5-million in federal funds. A further benefit would be improved staffing ratios in the remaining institutions through reassignments of professional personnel. This will enhance the department's overall ability to qualify for federal medical assistance payments, thereby increasing the potential income to the state.

Implementation Strategy: The deputy secretaries, Mental Health and Mental Retardation, should develop a program to identify and phrase out obsolete and unneeded facilities in accordance with the comprehensive regional facility plans. An aggressive approach to developing community programs and renovating usable residence buildings could bring about accomplishment of this objective within three years.

* * *

[62] **172. Close and demolish obsolete buildings at state MH/MR institutions.**

Many state institutions were built more than 40 years ago when the philosophy of patient care was significantly different. As a result, the buildings are both physically old and unsuitable for today's rehabilitation programs. In order to qualify for federal medical assistance grants, state institutions must conform to certain safety and staffing standards. To bring all institutional buildings, including many that are obsolete into conformance with these regulations would require an expenditure of about $60-million. Because patient populations are on the decline, a number of newer buildings are underutilized. Many of these can qualify for federal medical assistance grants.

Proposed Approach: The department should redistribute patients to appropriate institutional and community facilities in order to close buildings which will not be required within a three-year-period. This will make older institutions more manageable in terms of physical plant operations and resident populations. Staffing can then be adjusted to optimum levels. In addition, moving patients to more modern facilities will provide improved surroundings and increase the state's participation in federal assistance grants. Also, there is an estimated potential cost avoidance of $10-million through eliminating the need to renovate obsolete buildings. If a total of 90 buildings were closed, there would be a one-time cost of $4.5 million to demolish them.

Implementation Strategy: The department secretary should undertake the following activities:

- Continue the freeze on implementing federal renovation requirements.
- Review all residence facilities to identify those which should continue in operation and those which should be abandoned.

- Begin repairs and construction work on habitable buildings as soon as possible.
- Encourage community-level program development.
- Transfer residents in obsolete facilities to more appropriate locations.
- Ensure that all new facilities meet federal government requirements.

Overall, implementation of this proposal should require about two years to complete.

* * *

PARC Ex. 33

MONTGOMERY COUNTY • COURT HOUSE • NORRISTOWN, PENNSYLVANIA 19404

MENTAL HEALTH
MENTAL RETARDATION
DRUG AND ALCOHOL
PROGRAMS

HERMANN A. ROETHER, Ph.D., ADMINISTRATOR

February 28, 1977

TO: Russell G. Rice, Jr.
MR Commissioner, S.E. Region

FROM: Edward R. Manning

REGARDING: Need Assessment and Budget Projections on the Deinstitutionalization of Montgomery County Persons residing at Pennhurst Center

The Montgomery County population at Pennhurst Center as of 2/25/77 is 130.

The projected over all cost to the community program to deinstitutionalize the above population is $1,911,406.*

In summary, this is broken out as follows: (see attached pages)

RESIDENTIAL COSTS	
(based on 100% Pennhurst occupancy)	$1,393,886
DAY PROGRAMS	
(training and vocational)	455,520
SUPPORT PROGRAMS	
(additional impact on FRS)	52,000
(additional impact on out patient)	10,000
TOTAL	$1,911,406*

Following is a list of tables attached to show more specific information:

TABLE I

Montgomery County clients at Pennhurst Center Breakdown according to type of residential program

needed together with age, functional level and indications of multiple handicaps. (Names can be furnished immediately on request).

TABLE II

Breakdown of number and types of projects needed to serve the population, together with total costs, annual individual costs, and per diem rates.

TABLE III

Budget breakouts for each individual project.

TABLE IV

Cost breakout for needed programs.

Please note that all projections are based on programmatic information given by the Social Services Department of Pennhurst Center.

ERM/maf

Attachments *130 clients for 1 year at Pennhurst = $2,888,730

TABLE I
MONTGOMERY COUNTY CLIENTS
AT PENNHURST CENTER

76 - clients fully amb.
54 - clients multi-handicapped
130 - total clients

BREAKDOWN

76 - fully amb.; no sensory disability
3 - totally deaf
11 - hearing disabilities
10 - totally blind
2 - visually handicapped
9 - totally non-amb. (bed stay)
4 - amb. with assistance
11 - wheelchair
1 - amb. with assistance also hearing & visual handicapped
1 - wheelchair and also totally blind
1 - blind and hearing handicapped
1 - deaf and visual handicap
130 - clients

PENNHURST CENTER (Montgomery County clients)

37 clients need DMU facility
3 clients need Children's Development Home
8 clients need Children's Intensive Behavior Shaping
33 adult clients need Intensive Behavior Shaping
42 clients need long-term shelter
7 clients need short-term shelter
130 clients total

37 clients need DMU facility

Breakdown by Sex	Breakdown by Age	Breakdown Functional Level
25-men	8-teen years	1-mild
12-women	8-20 to 29	13-severe
37-clients	1-30 to 39	23-profound
	12-40 to older	37-clients
	8-age unknown	
	37-clients	

41 clients need Intensive Behavior Shaping Home

Breakdown by Sex	Breakdown by Age	Breakdown Functiona' Level
28-men	8-children	1-moderate
13-women	9-20 to 29	17-severe
41-clients	3-30 to 39	23-profound
	12-40 to older	41-clients
	9-unknown	
	41-clients	

3 clients need Children's Development Home

Breakdown by Sex	Breakdown by Functional Level
3-boys	1-moderate
	2-severe

42 clients need long-term shelter

Breakdown by Sex	Breakdown by Age	Breakdown Functional Level
32-men	7-20 to 29	1-mild
10-women	11-30 to 39	5-moderate
42-clients	16-40 to older	32-severe
	8-age old unknown	4-profound
	42-clients	42-clients

7 clients need short-term shelter

Breakdown by Sex	Breakdown by Age	Breakdown Functional Level
2-men	1-20 to 29	1-without retardation
5-women	4-30 to 39	1-mild
7-clients	2-40 to older	3-moderate
	7-clients	2-severe
		7-clients

TABLE II
ESTIMATED BUDGET FOR COMMUNITY RESIDENTIAL COSTS

Total Cost — $1,393,886.00

Intensive Behavior Shaping.
41 clients (6 homes)

$513,773.00 — total cost for 6 homes
34.33 — daily cost per resident
$12,531.00 — annual cost per resident

Long-term Sheltered
42 clients (5 homes)

$339,747.00 — total cost for 5 homes
22.16 — daily cost per resident
$8,089.00 — annual cost per resident

DMU (apartments)
37 clients (12 apts./3 persons per apt.)

$446,033.00 — total cost for 12 apts.
33.02 — daily cost per resident
$12,054.00 — annual cost per resident

Short-term Adult
7 clients (2 apts.)

$52,242.00 — total cost for 2 apts.
20.45 — daily cost per resident
$7,463.00 — annual cost per resident

Children's Developmental
3 clients (1 apt.)

$42,091.00 — total cost for 1 apt.
38.44 — daily cost per resident
$14,030.00 — annual cost per resident

TABLE IV

Cost Estimate for Day Service
-$18.00 a day for day activity center
-$14.00 a day for workshop
-240 days per year

Intensive Behavior Shaping Clients

-$142,560.00 cost for day activity center for one year serving 33 clients

Long-term Shelter

-$77,760.00 cost for day activity center for one year serving 18 clients

-$80,640.00 cost for workshop for one year for 24 clients

Developmental Maximation Unit

-$120,960.00 cost for day activity center for one year serving 28 clients

-$10,080.00 cost for workshop for one year serving 3 clients

Short-term Shelter

-$23,520.00 cost for workshop for one year serving 7 clients

TOTAL COST — $455,520.00

* * *

A988

PARC Ex. 38

A HISTORY OF PENNHURST 1908-1926

Robert Smilovitz, Ed.D.

Introduction

As you read the following you will, if you disregard dates, discern an almost eerie similarity to our present situation. High costs, few staff, crowded buildings, inadequate facilities, insensitive legislators, confused contradictory labeling, inappropriate placements, delinquents, etc. are all clearly documented. You will also find the etiological base of what we today call peonage, the medical model and institutionalization. In retrospect you can also read between these lines and conclude what you will.

A Brief History of Pennhurst 1908-1926
Compiled from Superintendent Reports*

Robert Smilovitz

1908

"The Institution was first opened for the reception of patients November 23, 1908. Only two buildings were at that time ready for occupancy as Ward Buildings, viz: buildings "T" and "Q". Owing to the pressing need and urgent demand for accommodations for patients, the Institution was opened before it was completed, thus entailing a very much greater operating expense than an Institution complete in all its parts."

" 'Youngest institution of its kind in Pennsylvania' before completion of buildings adapted for the various uses set forth in the Act under which the Institution was created. Incomplete as it was (and still is, for that matter), we yielded to the urgent demand for accommodations for the feebleminded and epileptic, and equipped two buildings as ward buildings."

"Building 'P' at present in use as Administration Building was designed for a Teachers' Building."

"Building 'Q' now used as a Low Grade cottage, was designed for a School Building."

"Building 'R' now used as a School Building was designed for an Industrial Building."

"Building 'F' now used as a Chapel and Amusement Hall, was designed for a dining room."

"The present Engineering Department for Storeroom purposes."

The fact is, that only three of the buildings at present occupied are used in their entirety for the purpose for which they were designed. These are "T", "U" and "V" and a portion of "U" is used as a hospital ward and a portion of "T" as a dispensary."

* * *

[2] "A number of the patients admitted during the first few months were transferred from Institutions for the Insane throughout this section of the State. A large percentage of them did not classify in a special Institution, and it was necessary to return a large proportion of them from time to time."

" 'Q' Building, as already stated, designed as a School Building, is being used as a cottage for low grades. The use to which it is put is as far from the use for which it was designed as opposites could possibly be. Its location, near the Administration Building, is objectionable, as this class of patients is always noisy, and should be kept near the central portion of the Institution.

"R" Building, designed as an Industrial Building, is being used both for this purpose and as a School Building.

Building "P", designed as an Employees' Home, is being used for this purpose, and also temporarily for administrative purposes.

Building "F", our only Assembly Hall and Chapel, was designed as a Dining Room for patients.

The second floors of Buildings "F," 'G" and "N," are all used as quarters for employees. This is a far from satisfactory arrangement, but it is the best we can do under existing conditions." (Where's the committee)

"During the first eighteen months of the Institution's existence there was considerable confusion as to the class of patients to be admitted, as the general public apparently did not understand the meaning of the terms "feeble-minded" and "epileptic." All sorts and classes of cases have been sent-the violently insane, with homicidal and suicidal tendencies; the maniac, with delusions of persecutions; the religious paranoiac, the paretic, with delusions of grandeur; cases of amentia, moral imbeciles, reformatory cases, criminals and so forth. The parents of these cases were content with the belief that sending children to a Special Institution did not place upon them the stigma which would result were the cases sent where they belonged, viz: to the Insane Asylum, the Reformatory and, in some cases, the jail.

Finally, this question, as to the class of cases to be admitted into this, a special institution, designed to handle a specific and definite class of cases, has apparently been settled. In order to arrive at a decision it has been needful for your Board to adopt certain rules and regulations. In the first place, it was necessary to obtain from the proper authorities the opinion that an insane individual is not a proper subject for classification in this institution." (How did you do it?)

* * *

[11] Building "K" Built — "received first inmates October 10, 1911 thus relieving the crowded condition of other buildings." Population increased from 313 (1910) to 466 (1912). Staff remained the same as 1908. (here we go)

"The increased cost of foodstuffs, and nearly all other materials and commodities, is the same serious factor here as everywhere. We are confronted with this condition at every point, and we meet it as a practical question must be met, realizing that cost determines maintenance. However, a proper economy, consistent with efficient administration and the general welfare of the wards of the State, is observed."

"This Institution is operated and maintained as economically as it is possible to conduct it, certain facts considered. The Institution was opened November, 1908. The period from that time to the present, covering the opening and organization, has been marked by the highest prices known in forty years. The effects of this changed condition the Institution has felt and continues to feel very keenly; but we realize that little else can be done than to adjust ourselves to it."

"Whilst our aim and effort is to conduct this Institution in conformity with the Act creating it, only male inmates are accepted. We have carefuly considered this question, and we have reached what we believe, under present conditions, to be a wise conclusion. When it is stated that we have no facilities for keeping the sexes entirely segregated, the reason for male inmates is obvious."

"As Trustees, we are aware how the number of degenerates in this Institution has increased; from what large families they come, as a rule; how rapidly applications for admission are coming in; that the reports are practically the same from other sections of the State. We are aware that this whole subject, in all its seriousness, has forced itself upon the attention of State bodies, medical associations, legislators, Judges of the Courts and other thoughtful persons. Everywhere the increase in the number of the institution classes is regarded as an alarming condition, growing in gravity far more rapidly than our great State is able to provide room and proper care in her numerous institutions. Further proof of this

unfortunate increase is not needed; all men are convinced, and agree that something must be done without delay." (1910)

* * *

(The primary prevailing philosophical thoughts of the past used to justify requests for more buildings and staff)

* * *

Prevailing philosophy

"The number of applications for admission is steadily increasing. We have been able to admit only a small proportion of these applicants, due to our lack of accommodations. For this increase in the number of applications for admission there are many reasons. The subject
[28] of feeble-mindedness has been much more largely discussed and written about during the past few years. Through various agencies, parents, physicians, teachers, courts, etc., have gained a better knowledge of the nature of feeble-mindedness and of the advisability of institutional care of the mental defective, and the public has come to realize that the feeble-minded child is entitled to that kind and degree of training compatible with its capacity. The helpless idiots and feeble-minded women and girls of child-bearing age are notably those for whom there is increasing demand for custodial care. There is no question that the irresponsible feeble-minded person, especially the feeble-minded woman or girl of child-bearing age, at large, is a menace from whom the community has a right to demand protection.

The increase in the number of feeble-minded persons in institutions at the present time and in the number of applications for admission to the Institution is not proof that feeble-mindedness in on the increase in our various communities, but it is rather the evidence that the people of the State are coming to a better under-

standing of the significance of feeble-mindedness and the need of permanent custodial care, not only from the need of the individual himself, but for social and economic reasons.

* * *

In such an Institution as this, where there is the combined care of the feeble-minded and epileptic, a large amount of time and attention is required by this latter type of case.

The tendency in almost all cases of continued epilepsy is for mental deterioration or mental loss to take place. Very few epileptics escape quite free from a certain amount of dullness. A certain percentage of these patients suffer at times from acute and severe mental disturbance, at which time they are much confused and often violent and dangerous. During the past year it became necessary to have a case of epileptic insanity transferred to a hospital for the insane, not only because we did not have the proper facilities for caring for such patients, but we could not subject our other children to the danger.

Where both feeble-minded and epileptic individuals are cared for in a single institution, no matter what degree of mental deterioration the epileptic may have, the arrangement of the Institution should be such as would permit of separating the different classes in different cottages or wards. Epileptics showing little or no mental deficiency should, of course, be separated from the other inmates, whether epileptic or feeble-minded only."

"We do not propose to create or supply faculties absolutely wanting; not to bring all grades of idiocy to the same standard of development and discipline; nor to make them all capable of sustaining credibility all the relations of a social and moral life; but rather to give to dormant faculties the greatest possible development, and to apply these awakened faculties to a useful purpose under the control of an aroused and disciplined will."

"The educational means at our disposal for the training of the feeble-minded child are physical (those addressed to the body) and mental (those addressed more particularly to the intelligence). But we must not lose sight of the fact that the two are not independent of each other. The specific exercises whether physical or mental should have for their direction a skilled teacher, acting in concert with the physician. The kind and amount of educational exercise as well as the kind and amount of industrial work appropriate to the individual case of mental deficiency should be prescribed by the latter.

The physical and mental means cannot be separated but they go hand in hand. In the words of "Seguin" the physiological education of the senses must precede the physical education of the mind.

Feeble-minded children show not only a lack of mental development but they are deficient in bodily development. Physical training is therefore necessary and serviceable for both muscular growth and coordination. The necessity of such training shows the need of a gymnasium properly equipped such as is found in all other institutions for the training of the feeble-minded.

The school and training department have been conducted along the lines described in the past reports. The pupils show great interest in the training work."

"To sum up, the program now possible includes the mental examination of backward school children, the mental clinic, the training clinic, the special class, directed training of individual defectives in country schools, instruction of parents of defective children, after care of special class pupils, special training of teachers in normal schools, census and registration of the feeble-minded, extra institutional supervision of all uncared for defectives who need segregation for institutional care, increased institutional facilities, parole for suitable institutionally trained adult defectives, permanent segregation for those who need segregation, mental

examination of persons accused of crime and all inmates of penal institutions, and long continued segregation of defective delinquents in special institutions."

Post Script

The only constant is change — but what direction does it take?

Robert S. Smilovitz, Ed. D.

PARC Ex. 40

PENNHURST IN PERSPECTIVE: PURPOSE, PROGRAMS, POSSIBILITIES

It is said that he who does not learn from the mistakes of history *will tend* to repeat them. The history of Pennhurst is replete with mistakes. We are committed to their *"amelioration."*

The custodial model with its emphasis on medical care and a dirth of individualized programming is reflected in statements from the recent past (1945); *"Patient"* population of 2,400 and a staff of 275! *"Patients* who are "absolutely hopeless for training." No routine letters; all correspondence addressed to the Superintendent; *"Patients"* forbidden to write letters for one another; no visiting on legal holidays; visiting *only* on Thursdays and Sundays from 9:00 a.m. to 4:00 p.m.; "do not give *"patients"* money when visiting for they are apt to lose it, spend it unwisely, or give it away"; and the ultimate goal is *"parole"* to the community! "Working patients", "female/male colonies", "defectives", overcrowding, deteriorated buildings, involuntary servitude, untrained staff, and on and on . . . . .

Created by an act of the legislature, Pennhurst opened its doors in 1908. It was immediately overcrowded and understaffed and has continued so. Relative to the tenor of their times, Pennhurst pursued the self-fulfilling prophecy of caring for the "hopeless" ones and showcasing the minimal program efforts for high functioning citizens who rarely, if ever, should have even been admitted to the institution.

This intolerable situation of warehousing persisted intact until the early 1960s. Then Federal action was initiated by President John Kennedy. In Pennsylvania, Statewide awareness was reflected in the MH/MR Act of 1966 which attempted to establish parameters of humane care and programming. However, the plight of the institutionalized citizen with retarded behavior was not

brought to public attention until 1968 when the media focused on Pennhurst. Typical reactions were those of shock, outrage and shame at man's inhumanity to his fellow man. The General Assembly passed Act 256 in 1970 which provided eight million dollars for improvement projects and twenty-one million to develop community-based facilities and services for approximately 900 Pennhurst citizens in order to reduce the population.

Officials in the Department of Public Welfare reacted to the public outcry for appropriate facilities and services by noting that "at the present time, there are approximately 1,000 students at Pennhurst living in utter squalor, housed in unsafe, unsanitary buildings, several previously planned for demolition to make room for new student cottages." Several plans were designed to reduce the population in a manner which would result in an increased staff/resident ratio and the vacating of all unsafe buildings. Though the plans are under way, the majority of Pennhurst citizens still live in unsafe, antiquated warehouses.

Yet, beneath the veneer of despair, the tremors of a dynamic, meaningful revolution reverberate throughout the institution and the State!!!

[2] Within purposeful, clarity-oriented management by objective parameters, Pennhurst is developing a behavioral programming approach which says every — yes, every citizen with retarded behavior can learn. Every citizen is entitled to rights implicit in the Declaration of Human Rights for the Mentally Retarded. No matter how severe the handicapping situation may be, every avenue is explored in developing constructive and positive approaches for the enhancement and betterment of self-dignity; the continuing development of full potential; and the development of a full productive life.

Through close cooperation with families, community resources, institutions of higher learning, and others, we establish both long and short term goals of com-

munity placement (not parole!). Through research, we engage in a constant search for meaningful, relevant, functional knowledge. Through data-based programming, we focus on the individual where he is and move sequentially and patiently through his own developmental hierarchy from one stage of treatment and development to other more complex stages.

The present Pennhurst model (within the material realities we are confronted with) is a heuristic one. The functioning Unit System is instructive for those who still pursue the authoritarian-hierarchical model. The three-stage workshop with an average weekly payroll of over one thousand dollars combined with a realistic scrip economy obliterates peonage and enhances the dignity of work. Functional on-ward behavioral inservice training liberates child care workers from custodial chains and cloaks them with programming skills. Multidisciplinary efforts focus on an individual program for every citizen — a program with definitive short and long term goals and procedures and strategies to achieve them. Simulated on-grounds community orientation programs ease the transition into the main stream community. Advocacy programs; sexuality education; mobility instruction; unique stimulus enriched environments; a communication center for the deaf; extensive volunteer resource efforts; over three hundred recent successful community placements; foster grandparents; data-based school programs; modular homes; and the list goes on.

The sum total of the differences between where Pennhurst was, presently is, and soon will be is immense. It is the difference between "hopeless ones" and all can learn. It is the difference between a "defective patient" and a citizen with retarded behavior. It is the difference between "seclusion" and "exclusion and contingency management and meaningful participation of all. It is the difference between "warehousing items" and providing homelike settings for individual human beings.

In a word, it is the difference between the inhumane and the humane. It is the difference between the Pennhurst of old and the Pennhurst of today.

FOR YOUR INFORMATION

Please write or call my office, Dr. Robert Smilovitz, 948-3500, ext. 268, for a description of any of the aforementioned programs; copies.

PARC Ex. 45

Philosophy, Purpose, Goals, and Objectives

Philosophy

The citizens committed to and residing at Pennhurst State School and Hospital exhibit a limited repertoire of effective and acceptable behaviors. Each individual's performance deficit had become apparent during his or her developmental years; it manifested as inadequacy in mental functioning; and it was associated with impairment in adaptive behavior. The "retardation" was a matter of *degree*, not of *kind*.

The staff at Pennhurst views the term "mental retardation" as a *description* (not a *cause*) of specific lower levels of mental functioning and non-adaptive behavior. Such descriptions of behavior can only arise from observation, measurement, and comparison of performances for a significantly large group of persons sharing the characteristic of "some chronological age". Scores within the group would vary widely, however the performances of a few persons would be judged as "subaverage" or as "retarded".

Causes of retardation are of interest to the staff, but primarily for purposes of preventing, future occurrences of retardation. However, knowing the probable cause of any one individual's retarded behavior does not, in itself, give specific direction to the practitioner (e.g., aide, teacher, therapist). For all persons, the development of any specified performance first requires the acquisition of certain pre-requisite skills. Such is true regardless whether or not the learner is suffering the effects of genetic errors, disease, bio-chemical conditions, or even retardation due to environmental educational or economic disadvantages.

Effects incurred, to close noted immediately above, are generally irreversible; however, the optimal levels of performance for an individual are not necessarily pre-determined by these effects. Consequently at Pennhurst,

the focus is not on the *retarded person* but rather is on the citizen with *retarded behavior*.

The men, women, boys, and girls, who reside at Pennhurst are citizens! They possess human, legal and social rights. As much as is possible, they are to be treated like any other ordinary persons of the same age. Their similarity to normal persons is to be emphasized and their deviant aspects, diminished. If institutionalization does become necessary, the commitment is to be perceived as *temporary;* a return to the community should be arranged just as soon as resources permit.

The statements above reflect the prevailing philosophy at Pennhurst and give rise to delineating the purpose, goals, and objectives of the facility.

Purpose

Pennhurst State School and Hospital exists to provide an environment designed to facilitate all aspects of growth and development of each handicapped citizen temporarily committed to its care so that this individual may live his life with as much dignity, happiness, independence, and usefulness as is inherent in him, both while he is living at the institution and when community resources are adequate to permit his return.

The purpose of the facility, as stated above, implies goals, some of which relate directly to the residents and others which extend beyond the institution, yet still indirectly affect the residents at Pennhurst. Quality care (e.g. health, safety, comfort) must be guaranteed at all times. Appropriate programming must be assured each and every resident. Thirdly, it is readily apparent that Pennhurst must play a significant role in the continuously developing state comprehensive program of providing a wide range of facilities and services for citizens with retarded behavior. Fourth, the facility must establish and maintain productive relationship with parents, families, community representatives, and institutions of higher learning to generate the resources so critically

needed to fulfill the current mission of the institution. Research activity, particularly as relevant to the evaluation of program strategies and tactics, is a noteworthy responsibility. Another focus is the training of institutional staff in recently formulated basic care and programming techniques; this training should be extended to staff of community-based residences and activity centers as well. Also indicated is the continuing development of a public relations and information dissemination system. Interestingly, all of the goals appearing above do relate to the protection and exercise of the human, legal, and social rights possessed by the citizens residing at Pennhurst.

Objectives

Pennhurst is resident-oriented. The Superintendent, Division Chiefs, Department Heads, and other supervisory personnel do prepare work plans in conjunction with the accountability system utilized at Pennhurst which is "Management by Objective". Objectives vary markedly in scope, nature, resources required, duration until fulfillment, etc. Yet each and every objective, so stated, must be consistent with the prevailing goals, purpose, and philosophy of the facility. For example, given the necessary resources: a) vacate ward L-3, an unsafe, warehouse-like living area by *(Date)*, b) reduce census on ward MVU by *(Date)* to comply with recommendations of Regional Standards and Licensing; c) provide personalized clothing for all citizens residing in Program Unit I by *(Date)*; and d) assure all child care aides have been trained and approved to administer medications by *(Date)*. It should be noted also that all objectives are to be as consistent with the "Normalization Principle" as is possible.

C. Duane Youngberg, Ed.D.
Superintendent

Reissued January, 1975

A1003

PARC Ex. 48

PENNHURST SURVEY RESULTS:

TABLE 1: ETHNICITY

	%
WHITE	75.8
BLACK	21.2
HISPANIC	3.0

TABLE 2: AGE

AGE	%
0-15	4.0
16-20	10.1
21-34	40.4
35 or older	45.5

MEAN	25.775	STD ERR	1.349	MEDIAN	32.330
MODE	30.413	SID DEV	13.420	VARIANCE	180.094

TABLE 3: AGE AT ENTRY

AGE	%
4	3.0
5	1.0
6	8.1
7	6.1
8	6.1
9	7.1
10	6.1
11	8.1
12	5.1
13	4.0
14	4.0
15	7.1
16	5.1
17	4.0
18	2.0
19	2.0
20	1.0

TABLE 3: AGE AT ENTRY (Continued)

AGE	%
21	4.0
22	2.0
23	2.0
24	2.0
25	2.0
31	2.0
36	1.0
37	2.0
38	1.0
39	2.0
TOTAL	100.0

MEAN	14.556	STD ERR	.837	MEDIAN	12.400
MINIMUM	4.000	MAXIMUM	39.000		

TABLE 4: YEARS AT PENNHURST

YEARS IN	PERCENT	CUMULATIVE PERCENT	
1	2.0	2.0	
2	4.0	6.1	
3	1.0	7.1	
4	8.1	15.2	
5	2.0	17.2	
7	2.0	19.2	
8	2.0	21.2	
9	2.0	23.2	
10	1.0	24.2	25%—in 10 or fewer years
11	3.0	27.3	
12	4.0	31.3	
13	3.0	34.3	
14	2.0	36.4	
15	2.0	38.4	
16	1.0	39.4	
17	1.0	40.4	

TABLE 4: YEARS AT PENNHURST (Continued)

YEARS IN	PERCENT	CUMULATIVE PERCENT	
18	1.0	41.4	
19	3.0	44.4	
20	2.0	46.5	
21	3.0	49.5	50%—In more than 21 years
22	2.0	51.5	
24	5.1	56.6	
25	3.0	59.6	
26	3.0	62.6	
27	5.1	67.7	
28	4.0	71.7	
29	2.0	73.7	
30	1.0	74.7	25%—In 31 or more years
31	4.0	78.8	
32	1.0	79.8	
34	1.0	80.8	
35	4.0	84.8	
36	2.0	86.9	
37	5.1	91.9	
39	2.0	93.9	
42	1.0	94.9	
43	1.0	96.0	
46	1.0	97.0	
55	1.0	98.0	
57	1.0	99.0	
61	1.0	100.0	
TOTAL	100.0	100.0	

TABLE 5: MOST RECENT MR CLASSIFICATION (IQ)

	%
NONMR	3.0
MILD	9.1
MODERATE	14.1
SEVERE	26.3
PROFOUND	47.5

TABLE 6: MOST RECENT MR CLASSIFICATION (AB)

	%
NONMR	1.0
MILD	10.1
MODERATE	15.2
SEVERE	31.3
PROFOUND	42.4

TABLE 7: EPILEPTIC

	%
NOT EPILEPTIC	72.7
EPILEPTIC	27.3

TABLE 8: CEREBRAL PALSY

	%
NOT CEREBRAL PALSY	78.8
CEREBRAL PALSY	21.2

TABLE 9: BLIND

	%
NOT BLIND	86.9
BLIND	13.1

TABLE 10: DEAF

	%
NOT DEAF	99.0
DEAF	1.0

TABLE 11: MOBILITY

	%
MOBILE	73.5
DEVICE ASSISTED	19.4
NON AMBULATORY	7.1

TABLE 12: COMMUNICATION

	%
VERBAL	72.2
GESTURES	15.5
NO COMMUNICATIONS	12.4

TABLE 13: FAMILY CONTACT

	%
CONTACT	56.7
NO CONTACT	43.3

TABLE 14: NUMBER OF PSYCHOLOGICAL EVALUATION REPORTS

NUMBER	%
0.	1.0
1.	8.1
2.	12.1
3.	15.2
4.	26.3
5.	18.2
6.	10.1
7.	1.0
8.	4.0
9.	4.0

MEAN 4.101 STD ERR .198 MEDIAN 4.019

TABLE 14B: NUMBER OF PSYCHOLOGICAL EVALUATION REPORTS PER YEAR

MEAN .289 MEDIAN .203

TABLE 15: NUMBER OF VOCATIONAL ADJUSTMENT SERVICE REPORTS

NUMBER	%
0.	68.4
1.	3.1
2.	7.1
3.	4.1
4.	6.1
5.	6.1
6.	2.0
7.	1.0
8.	2.0

MEAN 1.204 STD ERR .210 MEDIAN .231

TABLE 15B: NUMBER OF VOCATIONAL ADJUSTMENT SERVICE REPORTS PER YEAR

MEAN .090 MEDIAN .000

TABLE 16: NUMBER OF AUDIOLOGICAL SPEECH/HEARING REPORTS

NUMBER	%
0.	4.1
1.	14.4
2.	20.6
3.	16.5
4.	20.6
5.	6.2
6.	9.3
7.	4.1
8.	2.1
9.	2.1

MEAN 3.381 STD ERR .210 MEDIAN 3.15

TABLE 16B: NUMBER OF AUDIOLOGICAL SPEECH/HEARING REPORTS PER YEAR

MEAN .289 MEDIAN .16

TABLE 17: NUMBER OF OCCUPATIONAL THERAPY EVALUATION REPORTS

NUMBER	%
0.	47.5
1.	19.2
2.	5.1
3.	7.1
5.	1.0
6.	1.0
7.	3.0
8.	1.0
9.	6.1
10.	2.0
11.	2.0
12.	1.0
13.	1.0
15.	1.0
16.	1.0
24.	1.0

MEAN 2.687 STD ERR .449 MEDIAN .632

TABLE 17B: NUMBER OF OCCUPATIONAL THERAPY EVALUATION REPORTS PER YEAR

MEAN .316 MEDIAN .036

TABLE 18: NUMBER OF PROGRAM REVIEWS

NUMBER	%
0.	5.1
1.	7.1
2.	19.2
3.	23.2
4.	14.1
5.	11.1
6.	5.1
7.	4.0
8.	3.0
9. +	8.1

MEAN 3.828 STD ERR .239 MEDIAN 3.304

TABLE 18B: NUMBER OF PROGRAM REVIEWS PER YEAR

MEAN .367 MEDIAN .162

TABLE 19: PRESENCE OF A PROGRAM REVIEW AFTER JANUARY 1976

	%
PRESENT	75.8
ABSENT	24.2

TABLE 20: YEAR OF OLDEST VINELAND (SUBSET OF 48 CLIENTS)

YEAR	%
1940	2.1
1946	2.1
1948	2.1
1949	2.1
1950	6.3
1951	8.3
1952	8.3
1953	6.3
1954	2.1
1955	4.2
1956	2.1
1957	4.2
1958	6.3
1960	2.1
1961	2.1
1963	4.2
1964	2.1
1965	2.1
1966	4.2
1968	10.4
1969	2.1
1971	10.4
1972	2.1

TABLE 20B: SOCIAL QUOTIENT SCORE BASED ON OLDEST VINELAND

SCORE	%
10.	4.2
13.	2.1
14.	4.2
17.	2.1
18.	2.1
19.	2.1
20.	33.3
22.	2.1
23.	4.2
24.	2.1
27.	4.2
30.	4.2
32.	2.1
33.	4.2
34.	2.1
35.	2.1
36.	6.3
42.	2.1
44.	4.2
46.	2.1
49.	2.1
53.	2.1
61.	2.1
70.	2.1

MEAN 27.604 STD ERR 1.882 MEDIAN 20.500

TABLE 21: YEAR OF NEWEST VINELAND (SUBSET OF 48 CLIENTS)

YEAR	%
1953	2.1
1956	2.1
1959	2.1
1966	4.2

TABLE 21: YEAR OF NEWEST VINELAND (SUBSET OF 48 CLIENTS) (Continued)

YEAR	%
1969	4.2
1970	2.1
1971	16.7
1972	14.6
1973	10.4
1974	18.8
1975	12.5
1976	10.4

TABLE 21B: SOCIAL QUOTIENT SCORE BASED ON NEWEST VINELAND

SCORE	%
7.	2.1
8.	2.1
10.	6.3
11.	4.2
12.	2.1
13.	6.3
14.	2.1
15.	4.2
16.	2.1
17.	6.3
18.	2.1
19.	2.1
20.	35.4
21.	2.1
22.	4.2
24.	2.1
30.	6.3
35.	2.1
43.	2.1
49.	2.1
51.	2.1

MEAN 20.063 STD ERR 1.332 MEDIAN 19.735

TABLE 22: SOCIAL QUOTIENT SCORE CHANGE (NEWEST MINUS OLDEST)

DIFFERENCE IN SCORE	%
−50.	2.1
−31.	2.1
−24.	2.1
−21.	4.2
−18.	2.1
−17.	2.1
−16.	2.1
−14.	4.2
−13.	4.2
−12.	2.1
−11.	2.1
−10.	10.4
− 9.	2.1
− 8.	2.1
− 7.	4.2
− 6.	10.4
− 3.	6.3
− 2.	4.2
− 1.	2.1
0.	16.7*
1.	2.1
4.	2.1
6.	2.1
8.	2.1
9.	2.1
10.	2.1

*87.5% showed regression or no growth in social quotient

MEAN	−7.542	STD ERR	1.534	MEDIAN	−6.300

TABLE 23B: SOCIAL QUOTIENT SCORE CHANGE PER YEAR

MEAN	−.596	MEDIAN	−.585

PARC Ex. 54

ANALYSIS OF PROGRAMMING HISTORY OF PENNHURST CLIENTS PROPOSED FOR TRANSFER TO EMBREEVILLE

Responses to interrogatory number 1.11 were received for 68 clients proposed for transfer.

As of December 1976, the 68 people had been living at Pennhurst an average of 21.92 years.

The programs reported by the superintendent included certain unstructured activities such as "free time," and certain services such as public school and outside workshops which were not provided by Pennhurst. Nevertheless, all entries for all programming were included in this analysis. Many programs were reported without any duration or hours. These were not included. Approximately one out of eight programs had no hours reported.

The average time between a client's admission and the first reported program with hours attributed was 18.8 *years*.

The total number of hours of programming reported by the superintendant for the 68 people was 65,047. The 68 people have been at Pennhurst a total of 1,490 years. Thus, they are reported as having received 43.65 hours of programming per client per year. This translates to 7.2 minutes per client per day.

For the three years of programs with attributed hours, the 68 people were reported as having received 318 hours of programming per client per year. This translates to less than 1 hour per client per day.

A1015

PARC Ex. 55

PENNHURST WAITING LIST
TOTAL N = 2382

TABLE 1: LEVEL OF MENTAL RETARDATION — COMPLETE COUNT

Unknown	13.6%
Unmeasureable	17.9%
Profound	7.8%
Severe	16.1%
Moderate	24.3%
Mild	20.3%

TABLE 2: AGE — ON BASIS OF SAMPLE OF 711 NAMES

	0-16	17-20	21-34	35+
N	(291)	(121)	(225)	(74)
%	41%	17%	32%	10%

Approximate mean age = 20 years

TABLE 3: STATUS — COMPLETE COUNT

County Of Residence	In Pennsylvania State Institution	In Other Facility	At Home Or Placement Unknown	
Chester = 97	4	36	57	(4%)
Bucks = 233	17	86	130	(10%)
Mont. = 355	24	170	161	(15%)
Delaware = 357	19	164	174	(15%)
Philadelphia = 1340	47	291	1002	(56%)
	III-4.7%	747-31.4%	1524-64.0%	

PARC Ex. 56

Pennhurst State School and Hospital
Spring City, Pa. 19475
Social Service Department

Dispersal — By Calendar Year (January through December)
January 1, 1972 through May 31, 1976

I. To Community Living Arrangements

Year	Total Placed for Year	Returned to Pennhurst	Deaths in Placement	Discharged	Remaining on Leave Status on Pennhurst rolls
1972	11	0	1	9	1
1973	66	10	0	15	41
1974	60	14	1	8	37
1975	34	1	0	1	32
1976	6	1	0	1	4
Total to 5/31/76	177	26	2	34	115

A1016

II. To Other Community Placements

Year	Total Placed for Year	Returned to Pennhurst	To Other Pa. State Facility while on Leave	Deaths in Placement	Transferred To C.L.A. while on Leave	Discharged	Remaining on Leave Status on Pennhurst Rolls
1972	50	14	1*	2		26	7
1973	54	15			1	26	12
1974	30	5	1**			14	10
1975	14	2				8	4
1976	9					2	7
Total to 5/31/76	157	36	2	2	1	76	40

*White Haven State School and Hospital
**Embreeville MR Unit

Dispersal — by Calendar Year (January through December)
January 1, 1972 through May 31, 1976

III. To Pinehill Rehabilitation Center

Year	Transferred from Pennhurst	Paper Admissions	Returned to Pennhurst	Deaths	Discharged	Placed on Trial Visit	Remaining on Pennhurst Rolls
12/31/71	17			3	1		13
1972	81		2	8		3	68
1973	6	4	1				9
1974		20					20
1975	10	34		1			43
1976	1	4					5
Total to 5/31/76	115	62	3	12	1	3	158

A1017

IV. To Embreeville MH and MR Units

Year	To MR Unit	To MH Unit
1969	73	
1972	68	1
1973	131	1
1974	64	1
1975	1	1
1976		1
Total to 5/31/76	337	5

* * *

Dispersal — by Calendar Year
(January through December)
January 1, 1972 through May 31, 1976

V. To Woodhaven Center

1974	13
1975	80
1976	3
Total to 5/31/76	96

* * *

VI. To Other State Facilities

1972	6
1973	8
1974	7*
1975	5
1976	5
Total to 5/31/76	31

*Includes one resident placed at Elwyn who remains on OAA Status on Pennhurst Census — all others have been removed from rolls.

June 18, 1976

Waiting List Statistics

January 1, 1972 — 2219
May 31, 1976 — 2282

	Applicants placed on the Waiting List	Removals from the Waiting List
1972	144	137
1973	107	103
1974	93	79
1975	111	91
1976	33	15
Totals	(488)	(425)

Reasons for Removal listed below:

Admitted to Pennhurst	240
Parents request	3
Out-of-State	9
Whereabouts unknown	23
BSU request — no contact	1
Elwyn State List	2
DPW request	3
Deceased	70
Married	1
High functioning level	4
No longer need for institutionalization	13
Admitted to other facilities or transferred to their waiting list:	56

Philadelphia State
Embreeville
Selinsgrove
Laurelton
Woodhaven

Del. Co. Home (Fair Acres)

Haverford State
White Haven
Cresson
Pinehill
Rest Haven Nursing Home
Riverview (residing at)

Prepared by Lou Wilson

PARC Ex. 58

Carryover — County MH/MR Program
Fiscal Year 1975-76
(From Fiscal Year 1974-75)

MENTAL HEALTH/MENTAL RETARDATION ADMINISTRATIVE UNITS (BY REGION)

	BASE	CLA	CLAC	FRS	DDS	TOTAL
Southeastern Region (5 units)						
1. Bucks County	157,971	32,767	-0-	-0-	-0-	190,738
2. Chester County	84,030	7,978	-0-	8,179	36,087	136,264
3. Delaware County	-0-	15,506	619	-0-	-0-	16,125
4. Montgomery County	260,774	79,869	-0-	-0-	-0-	340,643
5. Philadelphia	1,109,985	214,841	-0-	-0-	142,905	1,467,731
Sub-Total	1,612,760	350,961	619	8,179	178,992	2,151,511

* * * *

Northeast, Central and Western Regions Omitted

A1020

Total Carryover By County MH/MR Unit
From Fiscal Year 1973-74

	BASE	CLA	CLAC	FRS	DDS	TOTAL
Southeastern Region (5 units)						
1. Bucks County	-0-	-0-	-0-	-0-	-0-	-0-
2. Chester County	62,752	1,437	4,587	25,679	4,143	98,598
3. Delaware County	-0-	112,332	13,979	-0-	-0-	126,311
4. Montgomery County	180,521	82,021	4,000	-0-	-0-	266,542
5. Philadelphia	-0-	321,026	-0-	142,611	18,105	481,742
Sub-Total	243,273	516,816	22,566	168,290	22,218	973,193

* * * *

Total Carryover By County MH/MR Unit
From Fiscal Year 1973-74

	BASE	CLA	CLAC	FRS	DDS	TOTAL
Southeastern Region (5 units)						
1. Bucks County	-0-	29,905	3,325	9,306	-0-	42,536
2. Chester County	29,793	5,232	-0-	2,011	-0-	37,036
3. Delaware County	-0-	-0-	-0-	-0-	62,898	62,898
4. Montgomery County	-0-	91,459	3,325	40,230	-0-	135,014
5. Philadelphia	911,783	606,475	-0-	104,597	188,302	1,811,157
Sub-Total	941,576	733,071	6,650	156,144	251,200	2,088,641

* * * *

A1021

County MH/MR Units	1 Gross Alloc., (Prog. Paymts. & C/O) (2 + 7)	2 1971-72 Carry-over	3 Base Alloc.*	4 Special Living Arrangements	5 Drug/Narc. Alcohol Progs.	6 DDS	7 Total Payments for Prog. (3+4+5+6)	8 SRS (4/30/72-3/31/73)	9 Total Payments to Counties (7+8)
Southeastern									
Bucks	1,850,878	162	1,503,937	53,345	293,434	-0-	1,850,716	120,510	1,971,226
Chester	1,121,581	65,825	730,611	92,415	232,730	-0-	1,055,756	33,343	1,089,099
Delaware	2,475,001	86,154	1,770,466	221,954	353,427	43,000	2,388,847	173,859	2,562,706
Montgomery	3,608,491	301,816	2,452,384	209,276	630,827	14,188	3,306,675	226,485	3,533,160
Philadelphia	21,369,543	1,395,142	17,216,933	801,758	1,435,390	520,320	19,974,401	3,773,836	23,748,237
Southeastern Total	30,425,494	1,849,099	23,674,331	1,378,748	2,945,808	577,508	28,576,395	4,328,033	32,904,428

* * * *

ALLOCATIONS AND EXPENDITURES FOR SOUTHEAST REGION

	Base (Includes CLAC)	Pennhurst Dispersal	FRS	CLA	Drug/ Alcohol	DDS
1967-68						
Allocations						
Bucks	22,805					
Chester	22,022					
Delaware	10,750					
Montgomery	12,636					
Philadelphia	23,844					
	92,057					
Expenditures	(NOT AVAILABLE)					
1968-69						
Allocations						
Bucks	24,466					
Chester	30,311					
Delaware	27,435					
Montgomery	31,405					
Philadelphia	159,170					
	272,787					
Expenditures	(NOT AVAILABLE)					

	Base (Includes CLAC)	Pennhurst Dispersal	FRS	CLA	Drug/ Alcohol	DDS
1969-70						
Allocations						
Bucks	846,952					
Chester	402,164					
Delaware	1,139,833					
Montogmery	1,224,165					
Philadelphia	10,986,503					
	14,599,617					
Expenditures						
Bucks	699,582					
Chester	352,105					
Delaware	816,813					
Montgomery	1,221,897					
Philadelphia	10,405,283					
	13,495,680					
1970-71						
Allocations						
Bucks	1,152,968					
Chester	592,601					
Delaware	1,400,116					
Montgomery	1,908,305					
Philadelphia	14,095,964					
	19,149,954					

	Base (Includes CLAC)	Pennhurst Dispersal	FRS	CLA	Drug/ Alcohol	DDS
Expenditures						
Bucks	1,152,968					
Chester	563,403					
Delaware	1,233,698					
Montgomery	1,893,068					
Philadelphia	14,095,964					
	18,939,101					
1971-72						
Allocations						
Bucks	1,349,550	-0-	-0-	-0-	57,609	-0-
Chester	835,784	-0-	-0-	45,500	35,964	-0-
Delaware	1,679,991	-0-	-0-	82,481	78,357	44,020
Montgomery	2,342,525	-0-	-0-	262,801	107,229	23,680
Philadelphia	15,350,529	-0-	-0-	514,629	833,119	123,900
	21,558,379	-0-	-0-	905,411	1,112,278	191,610
Expenditures						
Bucks	1,349,550	-0-	-0-	-0-	57,609	-0-
Chester	799,440	-0-	-0-	22,800	28,840	-0-
Delaware	1,673,091	-0-	-0-	40,409	78,357	-0-
Montgomery	2,334,717	-0-	-0-	12,476	62,832	16,590
Philadelphia	15,350,529	-0-	-0-	-0-	76,511	-0-
	21,507,327	-0-	-0-	75,685	304,149	16,590

	Base (Includes CLAC)	Pennhurst Dispersal	FRS	CLA	Drug/ Alcohol	DDS
1972-73						
Allocations						
Bucks	1,507,424	-0-	20,115	29,905	293,434	-0-
Chester	766,612	-0-	20,115	95,000	239,854	-0-
Delaware	1,770,525	-0-	32,184	231,842	353,427	87,023
Montgomery	2,455,709	-0-	40,230	416,046	675,224	21,282
Philadelphia	17,220,188	-0-	104,597	1,208,535	2,191,998	644,225
	23,720,458	-0-	217,241	1,981,328	3,753,937	752,530
Expenditures						
Bucks	1,507,424	-0-	9,306	29,905	251,346	-0-
Chester	736,819	-0-	2,011	5,232	229,854	-0-
Delaware	1,770,525	-0-	-0-	-0-	327,423	24,125
Montgomery	2,455,709	-0-	40,230	91,459	666,724	21,282
Philadelphia	16,305,150	-0-	104,597	606,475	578,893	455,923
	22,775,627	-0-	156,144	733,071	2,054,240	501,330
1973-74						
Allocations						
Bucks	1,661,906	-0-	100,993	64,490		-0-
Chester	891,874	-0-	72,137	142,392		24,500
Delaware	1,976,145	-0-	115,420	374,492		62,898
Montgomery	2,665,074	-0-	144,273	479,587		-0-
Philadelphia	18,802,267	-0-	375,106	1,184,865		214,212
	25,997,266	-0-	807,929	2,245,826		301,610

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	Base (Includes CLAC)	Pennhurst Dispersal	FRS	CLA	Drug/ Alcohol	DDS
Expenditures						
Bucks	1,661,906	-0-	100,993	64,490		-0-
Chester	824,535	-0-	4,458	140,955		20,357
Delaware	1,962,166	-0-	115,420	262,160		62,898
Montgomery	2,480,553	-0-	144,273	397,566		-0-
Philadelphia	18,802,267	-0-	232,495	863,839		214,212
	25,731,427	-0-	639,639	1,729,010		297,467
1974-75						
Allocations						
Bucks	2,059,749	2,115	112,852	198,793		-0-
Chester	1,134,964	-0-	60,379	235,208		41,143
Delaware	2,330,904	-0-	129,735	366,682		-0-
Montgomery	3,091,035	10,485	158,700	675,482		-0-
Philadelphia	20,538,588	14,562	257,300	1,394,579		329,251
	29,155,240	27,162	718,966	2,870,564		370,394
Expenditures						
Bucks	1,903,893	-0-	112,852	166,026		-0-
Chester	1,051,757	-0-	52,200	227,050		5,056
Delaware	2,330,285	-0-	129,735	351,176		-0-
Montgomery	2,836,246	4,500	158,700	595,613		-0-
Philadelphia	19,438,632	4,533	257,300	1,179,738		186,346
	27,560,813	9,033	710,787	2,519,603		191,402

	Base (Includes CLAC)	Dispersal	FRS	CLA	Drug/ Alcohol	DDS
1975-76						
Allocations						
Bucks	2,303,416	100,000	120,131	415,731		-0-
Chester	1,310,425	120,000	63,721	296,097		36,087
Delaware	2,822,219	-0-	135,151	493,155		-0-
Montgomery	3,329,917	10,650	168,936	685,141		-0-
Philadelphia	22,197,346	187,914	273,896	1,511,263		142,905
	31,963,323	418,564	761,835	3,401,387		178,992
Expenditures						
Bucks	2,303,416	100,000	120,131	415,731		-0-
Chester	1,310,425	111,155	63,730	284,272		36,08
Delaware	2,820,402	-0-	135,151	492,960		-0-
Montgomery	3,329,917	10,650	168,935	685,141		-0-
Philadelphia	22,197,346*	187,914*	273,896*	1,425,563*		142,90
	31,961,506*	409,719*	761,843*	3,303,667*		189,89

*Estimated

1976-77						
Allocations						
Bucks	2,530,133	353,180	141,883	726,103		
Chester	1,494,509	200,500	79,517	343,491		
Delaware	3,157,131	1,000	149,324	515,031		
Montgomery	3,688,637	420,000	168,936	950,966		
Philadelphia	24,293,047	460,320	314,809	1,586,132		
	35,163,457	1,435,000	854,469	4,121,723		

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PARC Ex. 63

Definitions of Community Living Arrangements Types

Type 1 *Developmental Maximation Unit:* An educational/residential program for the medically complex, multi-handicapped person, the establishing of a Developmental Maximation Unit is based on the belief that severely and profoundly retarded, multi-handicapped, medically complex individuals have developmental growth potentials, and can learn self-help skills. The primary objective of the Developmental Maximation Unit is to plan developmental programs directed towards moving each individual into a more normative residential and educational setting as quickly as possible. No more than twenty (20) individuals should reside in this type of program.

Type 2 *Intensive Behavior Shaping:* This residential program shall be for those persons not requiring Developmental Maximation care, yet not being ready to benefit from the more developmentally-and-training-oriented residential services. These individuals may be severely and profoundly retarded and/or may have very special problems. This residential service, most often a temporary one, emphasizes shaping and maintenance of basic habits. Each program is intended to serve up to a maximum of six individuals: 6 per home; 2 per apartment.

Type 3 *Structured Correctional:* This residential program for persons displaying serious behavior problems and consistently anti-social behavior consists of up to six persons, grouped by age (children's residence — aged 8-13, adolescent's residence — aged 14-18). This service should utilize a highly structured approach and inten-

sive supervision. Such an approach is necessary because of the dual considerations in providing a program which serves individuals who are both mentally retarded and delinquent. A structured correctional residence should be under the direction of an individual with experience in corrective habilitation.

Type 4 *Child Development:* The Child Development Program shall be for children from birth to age 18 who do not require Developmental Maximation care. This program shall enable children to develop self-help and social skills; toileting, feeding, dressing, communication, social courtesies, ambulation and/or mobility, etc. They will attend pre-school programs, public school classes, or appropriate day training programs. Each program is intended to serve 6 individuals; 6 per home; 2 per apartment setting.

Type 5 *Adult Long-Term Sheltered:* This residential service, for up to 8 individuals, is for those individuals who may not be capable of finding employment in competitive industry and will be retained in a vocational services center or day activity center for a prolonged period of time. The residential setting may be provided in a group home or apartments.

Type 6 *Adult Short-Term Training:* This residential service, for up to 8 individuals, is for adults, age 18 and over, who are involved in an active vocational training program or in some form of employment. This service should be intensively evaluation-and-training oriented. The typical length of stay should be about one year, as residents are expected to eventually move on into the community or another type of adult residence. The goal of this service is toward achiev-

ing the total, 24-hour self-sufficiency of the residents. Both group homes and apartments are utilized.

Type 7 *Adult Minimal Supervision:* This residential program shall be for those persons holding jobs in competitive or sheltered employment but who, if left to their own resources, might easily have experienced difficulty in finding or holding a job, in knowing how to recreate, and in working out problems of daily living. This program may utilize one of three different Apartment Living Models: (1) Apartment Cluster; (2) Co-Residence Apartment; and (3) Maximum Independence Apartments.

Type 8 *Family Relief:* This residential or non-residential service shall provide short-term care and supervision of persons who generally live in their own home. Maximum stay per residential admission should generally be one month at a time, and maximum resident time per client per year should be three months. This service is intended to: assist families surmount major and/or specific crises; relieve the continuity of family stress; and, to provide non-residential supervision for part of a day or evening, both for crisis as well as stress relief. Each program is intended to serve 12 individuals.

PARC Ex. 64

OFFICE OF MENTAL RETARDATION
DEPARTMENT OF PUBLIC WELFARE
COMMONWEALTH OF PENNSYLVANIA

COMMUNITY LIVING ARRANGEMENTS FOR MENTALLY RETARDED CITIZENS

Population and Dispersal Report Through June, 1976

Since Program was Initiated:

Through June 30, 1976

State Population in Programs	2,069
State Population Dispersed	1,368
Total State Population Served	3,437

As of June 30, 1976

Total State Population (In Programs)	2,069
Residents from State MR Institutions	853
Residents from State MH Institutions	74
Residents from Community	989
Residents from Private Licensed Facilities	139
From Nusing Homes	14
Dispersed to Independent Living	640
Dispersed to State Schools	157
Dispersed to Nursing Homes	29
Dispersed to Family	377
Dispersed to Foster Homes	70
Dispersed to Others	95

MONTHLY REPORT:

June 1 to June 30, 1976

State Population Entering Programs	48
State Population Dispersed	46

Total State Population Served during June in Programs and Dispersed 2,069 + 46 = 2,115

June 1 through June 30, 1976

State Population Entering Programs	48
Residents from State MR Institutions	13
Residents from State MH Institutions	1
Residents from Private Licensed Facilities	3
Residents from Nursing Homes	0
Residents from Community	31
Dispersed to Independent Living	8
Dispersed to State Schools	4
Dispersed to Nursing Homes	2
Dispersed to Family	27
Dispersed to Foster Homes	0
Dispersed to Others	5
Dispersal Total	46

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BREAKDOWN BY REGION

As of June 30, 1976

June 1 through June 30, 1976

	III Programs	From MR	From MH	From PLE	From Comm.	From MH	Entered Program	From MR	From MH	From PLE	From Comm.	From Nursing Homes
Southeastern Region	483	180	6	21	276	—	1	1	0	0	0	0
Northeastern Region	370	116	14	47	192	1	9	0	0	1	8	0
Central Region	525	239	21	54	208	3	20	6	0	2	12	0
Western Region	691	318	33	17	313	10	18	6	1	0	11	0

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DISPERSAL BREAKDOWN

Through June, 1976

June 1 through June 30, 1976

	Ind. Liv.	State Schools	Nurs. Homes	Ret. to Fam.	Fos. Homes	Ind. Liv.	State Schools	Nurs. Homes	Ret. to Fam.	Fos. Home
Southeastern Region	48	26	4	62	14	0	1	0	3	0
Northeastern Region	58	31	2	81	16	0	0	0	17	0
Central Region	166	45	7	89	22	4	1	2	1	0
Western Region	368	55	16	145	18	4	2	0	6	0
Totals	640	157	29	377	70	8	4	2	27	0

OTHER DISPERSAL CATEGORIES

	PLF	B.H.	MH	Training Facility	*CLA Residents Moving to Other CLA Programs
Southeastern Region	0	0	0	0	3
Northeastern Region	0	1	1	0	2
Central Region	0	0	0	1	6
Western Region	1	0	1	1	3
Totals	1	1	2	2	14

*NOT TO BE INCLUDED AS "DISPERSAL"

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COMMUNITY LIVING ARRANGEMENTS FOR MENTALLY RETARDED CITIZENS

POPULATION AND DISPERSAL REPORT FROM JULY 1, 1975 THROUGH JUNE 30, 1976

SUMMARY OF FISCAL YEAR 75-76

STATE POPULATION IN PROGRAMS AS OF JUNE 30, 1976	2,069
STATE POPULATION DISPERSED DURING FY 1975-76	558
TOTAL STATE POPULATION SERVED DURING FY 1975-76	2,627

DISPERSAL BREAKDOWN
(JULY 1, 1975 THROUGH JUNE 30, 1976)

	Indep. Living	State Schools	Nursing Homes	Ret. to Family	Foster Homes	Other	Total
Southeast	17	12	1	30	11	8	79
Northeast	35	14	0	62	10	8	129
Central	71	13	3	41	12	21	161
Western	58	13	10	82	4	22	189
Totals	181	52	14	215	37	59	558

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OFFICE OF MENTAL RETARDATION
DEPARTMENT OF PUBLIC WELFARE
COMMONWEALTH OF PENNSYLVANIA

COMMUNITY LIVING ARRANGEMENTS FOR MENTALLY RETARDED CITIZENS

OPERATIONAL DATA AS OF JUNE 30, 1976

Regions	Persons Funded	Residents In Programs	Group Homes	Apts.	Operating: Child Family Placement Homes	Operating: Adult Family Placement Homes
Southeastern	580	483	33	58	19	72
Northeastern	457	370	18	115	37	20
Central	529	525	36 + 2 DMU	82	16	41
Western	714	691	37	160	13	27
Totals:	2,280	2,069	124 + 2 DMU	415	85	160

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OPERATIONAL DATA BY REGION AND COUNTY
(AS OF JUNE 30, 1976)

Southeastern Region	Residents In Programs	Group Homes	Apts.	Operating: Child Family Placement Homes	Operating: Adult Family Placement Homes
Bucks County	37	3	8	0	0
Chester County	58	3	12	0	6
Delaware County	64	5	9	0	12
Montgomery County	106	7	11	19	12
Philadelphia County	218	15	18	0	48
Northeastern Region					
Berks County	55	4	19	4	0
Carbon-Monroe-Pike	33	4	6	3	1
Bradford-Tioga-Sullivan	31	3	5	5	0
Lack.-Sus.-Wayne	26	2	6	0	0
Luzerne-Wyoming	73	2	33	4	7
Schuylkill County	26	2	5	0	0
Lehigh County	84	1	25	20	1
Northampton County	42	0	16	1	11
Central Region					
Blair County	42	3	6	1	14
Cambria County	22	1	5	6	0
Centre County	26	3	2	0	0
Cumberland Perry	34	3	7	0	2
C-M-S-U	26	1	2	3	0
Dauphin County	78	4 + 1 DMU	11	0	5

Central Region	Residents In Programs	Group Homes	Apts.	Operating Child Family Placement Homes	Operating Adult Family Placement Homes
Hunt-Mifflin-Juniata	17	2	0	3	1
Lancaster County	68	5	13	0	0
Lycoming-Clinton	71	3	27	0	12
Somerset-Bedford	65	5	0	3	7
York-Adams	39	4	6	0	0
Franklin-Fulton	21	2	3	0	0
Lebanon	16	1 DMU	0	0	0
Northumberland	0	0	0	0	0
[PAGE 6] *Western Region*					
Allegheny County	252	6	100	0	0
Beaver County	20	1	6	0	0
Butler County	15	2	0	0	0
C-E-M-P	79	9	0	3	5
Mercer County	51	1	16	6	2
Clarion-Forest-Venango-Warren	42	2	3	2	15
Erie County	119	8	9	0	0
Armstrong-Indiana	7	1	1	0	0
Clearfield-Jefferson	16	1	10	2	0
Fayette	26	1	7	0	0
Washington-Greene	15	2	0	0	0
Westmoreland County	42	3	8	0	0
Crawford	0	0	0	0	0
Lawrence	7	0	0	0	4

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PARC Ex. 65

DEPARTMENT OF PUBLIC WELFARE

SUMMARY OF FISCAL ACTIVITY

FISCAL YEAR 1975-1976

Prepared By:
Bureau of Fiscal Management
August 20, 1976

COUNTY MH/MR PROGRAM

[59] The County MH/MR Program was appropriated $75.542 million State funds for Base Program services and $14.611 million for MR Programs for total appropriated funds of $90.153 million. An additional $6.0 million was also available for re-allocation from unspent State funds carried over from Fiscal Year 1974-75 programs. The total funds allocated to the counties during the year by type of service and source of funds is shown on the Total Commitments chart following these remarks.

In the Base Program a total of $75.2 million was allocated to the counties this year. The major portion of the funds, $63.9 million, provided for an 8% increase over each county's prior year expenditures which total $59.2 million. In addition, funding was provided to those counties with a per capita allocation of less than $4.00 to bring them up to this level. Also an allotment of $15.00 per day per unit of service was allocated to each county providing interim care for the mentally retarded. The balance of funds were distributed to counties providing for special projects such a. Pennhurst Dispersal, and various other deinstitutionalization pilot projects.

The Community Living Arrangements Program received a total of $13.8 million to provide for about 2,764 clients residing in CLA settings and an additional 1,389 people dispersed into the community or to State Schools or Nursing homes. Approximately 54% of the persons residing in CLA's were previous residents of State institutions.

In addition to the State funds available this year $1.3 million in Federal augmentations was available. The Public Health Service Grant of $639,324 was used to fund the Student Intern Program and mental health training and demonstration projects. The Developmen-
[60] tal Disabilities Service grant of $661,705 is used to fund training and demonstration projects for MR Programs.

This includes $352,022 which was carried over from the prior year and reallocated to the counties. A total of $13.8 million was earned and reimbursed to the counties from Federal Social Service funds during the fiscal year.

Among the fiscal policies for the County MH/MR Program addressed by the Department this year were the establishment of per diem rates for interim care based upon reasonable costs; clarification of overhead costs and the reporting of earned interest; and start up costs for fee-for-service programs such as short term inpatient and partial hospitalization. The Department also compiled and published a handbook containing all current fiscal policies relative to the administration of the County MH/MR Program.

The two charts which follow include the Total Commitments Summary and the Schedule of 1975-76 Allocations which lists allocations by categorical program and County MH/MR Unit.

COUNTY MH/MR PROGRAM
1975-76 Total Commitments

	Current Funds (State/Fed)	Carryover	Total Allocation
Base Program			
Base + 8% Cost of Living Increase	$63,932,893	-0-	$63,932,893
Full Yr. Cost of Special Projects	-0-	151,178	151,178
Student Intern Program	130,500	-0-	130,500
Interim Care	9,305,710	-0-	9,305,710
$4.00 Per Capita	830,017	-0-	830,017
Special Programs & Pilot Projects	1,039,898	278,455	1,318,353
Carryover Distribution	-0-	3,789,453	3,789,453
Total Base (Approp. 43)	$75,239,018	$4,219,086	$79,458,104
MR Programs			
CLA	11,734,175	1,591,489	13,325,664
CLA Coordinator	486,366	34,899	521,265
Family Resource Services	2,390,459	200,541	2,591,000
TOTAL MR (Approp. 57)	$14,611,000	$1,826,929	$16,437,929
Developmental Disabilities Services (Approp. 43)	-0-	352,022	352,022
Total County Grants	$89,850,018	$6,398,037	$96,248,055

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	Current Funds (State/Fed)	Carryover	Total Allocation
Administration			
State	403,482	-0-	403,482
Federal	682,196	166,311	848,507
TOTAL ADMINISTRATION (Approp. 43)	$ 1,085,678	$ 166,311	$ 1,251,989
Grand Total County Program	$90,935,696	$6,564,348	$97,500,044
State 43	$75,542,000	$4,219,086	$79,761,086
State 57	14,611,000	1,826,929	16,437,929
Federal PHS	635,500	3,824	639,324
Federal DDS	147,196	514,509	661,705

DEPARTMENT OF PUBLIC WELFARE

Comparison of Actual Commitments and Expenditures between 1974-1975 and 1975-1976 as of June 30, 1976
Mental Health/Mental Retardation Services

* * *

	1974-1975 Actual			1975-1976 Actual			Increase (Decrease) 1975-1976 Over (1974-1975)			Percent
	State	Augmen-tations	Total	State	Augmen-tations	Total	State	Augmen-tations	Total	Increase (Decrease)
Institutions for Mentally Ill Omitted.										
MR-ICF Units at State Hospitals										
Allentown	-0-	165,238	165,238	243,142	133,654	376,796	243,142	(31,584)	211,558	128.03
Clarks Summit	-0-	287,925	287,925	214,777	148,811	363,588	214,777	(139,114)	75,663	26.28
Embreeville	-0-	3,230,017	3,230,017	1,198,838	3,350,809	4,549,647	1,198,838	120,792	1,319,630	40.86
Harrisburg	870,240	17,845	888,085	297,428	776,753	1,074,181	(572,812)	758,908	186,096	20.95
Hollidaysburg	-0-	278,290	278,290	231,216	145,373	376,589	231,216	(132,917)	98,299	35.32
Mayview	345,373	66,748	412,121	304,767	366,504	671,271	(40,606)	299,756	259,150	62.88
Norristown	9,468	9,256	18,724	27,280	30,738	58,018	17,812	21,482	39,294	209.86
Somerset	-0-	499,859	499,859	438,053	150,242	588,295	438,053	(349,617)	88,436	17.69
Torrance	660,366	90,226	750,592	413,466	475,617	889,083	(246,900)	385,391	138,491	18.45
Warren	371,723	244,592	616,315	272,787	478,731	751,518	(98,936)	234,139	135,203	21.94
Wernersville	-0-	296,544	296,544	261,842	144,720	406,562	261,842	(151,824)	110,018	37.10
SUBTOTAL	2,257,170	5,186,540	7,443,710	3,903,596	6,201,952	10,105,548	1,646,426	1,015,412	2,661,838	35.76

	1974-1975 Actual			1975-1976 Actual			Increase (Decrease) 1975-1976 Over (1974-1975)			Percent
	State	Augmen-tations	Total	State	Augmen-tations	Total	State	Augmen-tations	Total	Increase (Decrease)
Institutions for Mentally Retarded										
Cresson	4,685,244	3,768,817	8,454,061	3,489,082	5,763,578	9,252,660	(1,196,162)	1,994,761	798,599	9.45
Ebensburg	7,355,843	6,323,248	13,679,091	5,793,925	9,400,147	15,194,072	(1,561,918)	3,076,899	1,514,981	11.08
Hamburg	4,379,781	5,512,857	9,892,638	4,413,829	7,097,490	11,511,319	34,048	1,584,633	1,618,681	16.36
Laurelton	3,495,879	3,808,642	7,304,521	4,196,157	4,276,937	8,473,094	700,278	468,295	1,168,573	16.00
Pennhurst	21,566,637	6,188,915	27,755,552	23,851,874	7,984,281	31,836,155	2,285,237	1,795,366	4,080,603	14.70
Polk	24,144,680	3,726,497	27,871,177	32,241,081	5,903,232	38,144,313	8,096,401	2,176,735	10,273,136	36.86
Selinsgrove	8,671,545	9,456,017	18,127,562	7,300,138	13,777,742	21,077,880	(1,371,407)	4,321,725	2,950,318	16.28
Southeastern	5,934,913	36,170	5,971,083	7,528,000	2,336,371	9,864,371	1,593,087	2,300,201	3,893,288	65.20
Western State Sch. and Hospital	7,202,595	3,726,513	10,929,108	6,695,367	5,356,503	12,051,870	(507,228)	1,629,990	1,122,762	10.27
White Haven	5,691,781	7,210,967	12,902,748	4,673,101	9,835,071	14,508,172	(1,018,680)	2,624,104	1,605,424	12.44
C. Howard Marcy	855,338	561,527	1,416,865	2,766,315	1,585,052	4,351,367	1,910,977	1,023,525	2,934,502	207.11
SUBTOTAL	93,984,236	50,320,170	144,304,406	102,948,869	73,316,404	176,265,273	8,964,633	22,996,234	31,960,867	22.15

Comparison of actual commitments and expenditures between 1974-1975 and 1975-1976 as of June 30, 1976 Mental Health/Mental Retardation Services

Additional Staff									
Allentown	$ 35,510	$ -0-	$ 35,510	$ -0-	$ -0-	$ -0-	$ (35,510)	$ -0-	$ (35,510)	(100.00)
Clarks Summit	22,771	-0-	22,771	-0-	-0-	-0-	(22,771)	-0-	(22,771)	(100.00)
Danville	82,951	-0-	82,951	-0-	-0-	-0-	(82,951)	-0-	(82,951)	(100.00)
Dixmont	25,826	-0-	25,826	-0-	-0-	-0-	(25,826)	-0-	(25,826)	(100.00)
Eastern St. Sch. and Hospital	59,247	-0-	59,247	-0-	-0-	-0-	(59,247)	-0-	(59,247)	(100.00)
Farview	13,700	-0-	13,700	-0-	-0-	-0-	(13,700)	-0-	(13,700)	(100.00)
Harrisburg	66,756	-0-	66,756	-0-	-0-	-0-	(66,756)	-0-	(66,756)	(100.00)
Haverford	78,135	-0-	78,135	-0-	-0-	-0-	(78,135)	-0-	(78,135)	(100.00)
Hollidaysburg	7,567	-0-	7,567	-0-	-0-	-0-	(7,567)	-0-	(7,567)	(100.00)
Mayview	50,209	-0-	50,209	-0-	-0-	-0-	(50,209)	-0-	(50,209)	(100.00)

	1974-1975 Actual			1975-1976 Actual			Increase (Decrease) 1975-1976 Over (1974-1975)			Percent
	State	Augmen-tations	Total	State	Augmen-tations	Total	State	Augmen-tations	Total	Increase (Decrease)
Norristown	122,318	-0-	122,318	-0-	-0-	-0-	(122,318)	-0-	(122,318)	(100.00)
Somerset	30,228	-0-	30,228	-0-	-0-	-0-	(30,228)	-0-	(30,228)	(100.00)
Torrance	58,425	-0-	58,425	-0-	-0-	-0-	(58,425)	-0-	(58,425)	(100.00)
Warren	33,699	-0-	33,699	-0-	-0-	-0-	(33,699)	-0-	(33,699)	(100.00)
Wernersville	17,034	-0-	17,034	-0-	-0-	-0-	(17,034)	-0-	(17,034)	(100.00)
Woodville	106,153	-0-	106,153	-0-	-0-	-0-	(106,153)	-0-	(106,153)	(100.00)
Cresson	118,326	-0-	118,326	-0-	-0-	-0-	(118,326)	-0-	(118,326)	(100.00)
Ebensburg	157,975	-0-	157,975	-0-	-0-	-0-	(157,975)	-0-	(157,975)	(100.00)
Hamburg	57,760	-0-	57,760	-0-	-0-	-0-	(57,760)	-0-	(57,760)	(100.00)
Laurelton	81,751	-0-	81,751	-0-	-0-	-0-	(81,751)	-0-	(81,751)	(100.00)
Pennhurst	290,572	-0-	290,572	-0-	-0-	-0-	(290,572)	-0-	(290,572)	(100.00)
Southeastern	7,770	-0-	7,770	-0-	-0-	-0-	(7,770)	-0-	(7,770)	(100.00)
Polk	158,279	-0-	158,279	-0-	-0-	-0-	(158,279)	-0-	(158,279)	(100.00)
Selinsgrove	191,242	-0-	191,242	-0-	-0-	-0-	(191,242)	-0-	(191,242)	(100.00)
Western	124,365	-0-	124,365	-0-	-0-	-0-	(124,365)	-0-	(124,365)	(100.00)
White Haven	45,431	-0-	45,431	-0-	-0-	-0-	(45,431)	-0-	(45,431)	(100.00)
C. Howard Marcy	456,000	-0-	456,000	-0-	-0-	-0-	(456,000)	-0-	(456,000)	(100.00)
SUBTOTAL	2,500,000	-0-	2,500,000	-0-	-0-	-0-	(2,500,000)	-0-	(2,500,000)	(100.00)
Resident Population Dispersal										
Polk	500,000	-0-	500,000	-0-	-0-	-0-	(500,000)	-0-	(500,000)	(100.00)
County Program										
Community Services	67,630,000	636,076	68,266,076	75,542,000	849,650	76,391,650	7,912,000	213,574	8,125,574	11.90
Small Units	13,596,000	940,998	14,536,998	14,611,000	-0-	14,611,000	1,015,000	(940,998)	74,002	.51
SUBTOTAL	81,226,000	1,577,074	82,803,074	90,153,000	849,650	91,002,650	8,927,000	(727,424)	8,199,576	9.90
GRAND TOTAL	$367,469,000	$123,647,531	$491,116,531	$389,632,000	$162,547,579	$552,179,579	$22,163,000	$38,900,048	$61,063,048	12.43

PARC Ex. 66

[1] **COUNTY MENTAL HEALTH & MENTAL RETARDATION PROGRAM**

Service Content of the Program **5200 Appendix IV**

Effective February 10, 1973 **DPW-MH&MR MANUAL**

MENTAL RETARDATION RESPONSIBILITIES

The County Program is the means by which minimum services as described in the Act shall be readily available to promote the social, personal, physical and economical habilitation or rehabilitation of mentally retarded persons with all due respect for the full human, social and legal rights of each person. This means that the health, social, educational, vocational, environmental and legal resources that serve the general population shall be marshalled and coordinated by the County Program to meet the personal development goals of mentally retarded persons, in accordance with the principle of normalization. *Normalization* means to ensure for every mentally retarded person and his family the right to live a life as close as possible to that which is typical for the general population. The mandated services, the provision of service mechanisms and the fiscal support of the program must all be used to secure for each person and his family the conditions and circumstances of day to day life that come as close as possible to representing normal life patterns.

In keeping with this principle of normalization, the County is responsible to utilize County Program funds for the mentally retarded to accomplish the following objectives:

1. Primary prevention of mental retardation — organic and functional;
2. Earliest possible case finding and diagnosis;
3. Medical and surgical correction or amelioration of systemic defects where possible;

[2] 4. Shaping and maintaining an environment most productive of basic human personality qualities involving parent-child and sibling relationships, environmental adaptation, self-awareness and learning motivation and ability;

5. Specific training and learning situations designed and implemented to develop all potential;

6. Community development and restructuring to achieve the maximum normalization for the mentally retarded person wherever he is.

I. Responsibility for Planning, Direction and Coordinated Delivery of Services — The Base Service Unit:

The County Administrator shall be responsible to provide for the establishment of an organizational unit consisting of multidisciplinary professional and nonprofessional staff capable to plan, direct and coordinate appropriate services for persons who are mentally retarded and in need of service from the County Program. This unit shall be called the Base Service Unit and the County Administrator shall have the authority to direct, control and monitor the activities of the Base Service Unit. The Base Service Unit shall be responsible to perform the following functions in such a way as to carry out the objectives of the County Program as stated above.

A. Establish or develop a system utilizing or developing preventive services in the community for the mentally retarded;

B. Establish and operate a system for earliest possible casefinding;

[3] C. Constitute a fixed point or referral and information for mentally retarded persons and their families;

D. Provide for comprehensive diagnosis and evaluation services to:

1. Diagnose, appraise and evaluate mental retardation and associated disabilities; define

the strengths, skills, abilities and potentials for improvement of the individual;

2. Assess the needs of the individual and his family;

3. Develop a practical life-management plan for the individual and his family and provide the necessary counseling and follow-along services.

4. Reassess the progress of the individual at regular intervals to determine his continuing need for service and/or for changes in his management plan (see Section II-A, 1, b (1) and (2)).

E. Maintain a continuing relationship with the mentally retarded person and with any facility or provider of service responsible for service to the mentally retarded person during any stage of his life management process;

[4] F. Initiate, develop and maintain a pattern of interaction between the diagnostic and evaluation team and others concerned with services to any mentally retarded person and/or his family. This pattern should emphasize, but not be limited to, participation of such persons in the life-management planning process as the family physician, local public health nurse, teacher, representatives of human service resources, vocational rehabilitation counselor, other providers of service, the family, advocates — informal or formal, and the mentally retarded person himself whenever possible;

G. Provide opportunities for advancing the knowledge and understanding of persons inside and outside its immediate setting, particularly those who have a responsibility in carrying out the life management process.

H. Foster cooperation through the use of a multidisciplinary approach;

I. Ensure that:

1. Where service to the mentally retarded is provided by other than the BSU and the mentally retarded person is referred for intake into the County Program, the referring agency and/or provider of service shall be invited to cooperate with the BSU in diagnosing, evaluating and planning for the person at that particular time of his life.

[5] 2. No service shall be authorized for funding by the County Program unless it is consistent with the life management plan as developed by the BSU and approved by the County Administrator.

II. Intake Into the County Program

A. All intake into the County Program shall be through the Base Service Unit.

1. The condition and circumstances of each person presumed to require service shall be thoroughly assessed before any disposition is made of his referral:

a. If it is determined after such assessment that the person does not at that time require further service from the BSU, the following information shall be recorded on the Intake and Proposed Service Plan, Form MH/MR 10:

(1) the presenting problem,

(2) the results of the assessment, and

(3) the disposition of the case (alternative referral of recommendation)

b. If it is determined after such assessment that the person requires service, he shall be provided with coordinated services necessary to identify: (1) the presence

[6] of mental retardation; (2) its cause and complications; and (3) the extent to which mental retardation limits (or is likely to

limit the person's daily living and work activities.

(1) These services shall include a systematic appraisal of said findings in terms of pertinent physical, psychological, vocational, educational, cultural, social, economic, legal, environmental and other factors of the mentally retarded person and his family:

(a.) To determine how and to what extent the disabling condition(s) may be expected to be removed, corrected or minimized by services;

(b.) To determine the nature and scope of services to be provided;

(c.) To select the service objectives which are commensurate to the person's interests, capacities and limitations;

(d.) To devise an individualized program of action to be followed, at the intervals needed, by periodic reappraisals; and

[7] (e.) To reevaluate progress of the person at intervals as necessary for such periodic appraisal.

(2) Each program service authorized shall have a service objective in keeping with each mentally retarded person's personal development goal, which goal shall be the basis for individualized life management planning.

(a.) This information shall be recorded on the Intake and Proposed Service Plan, Form MH/MR 10, along with a listing of the counseling, follow-along and other services to be provided within a specified period of time in coordinated association with the program service immediately authorized.

(b.) A specific date for evaluation of the person's progress and reevaluation of his life-management plan shall also be part of the Intake and Proposed Service Plan.

(c.) In all cases the mentally retarded person's family and the social, economic, cultural, educational, vocational, legal and
[8] environmental circumstances affecting him as well as his physical and psychological condition, shall be considered essential aspects of his life-management plan.

III. Aftercare Services:

Aftercare services shall be available to prevent unnecessary and prolonged institutionalization and to facilitate the return of persons to their homes or communities. These services shall be designed to enable persons who are mentally retarded to achieve their maximum potential for self-care, self-support, self-sufficiency and social competence.

A. Evaluation of persons currently in residential placement;

B. Preparation of individual life-management plans for persons in placement to include a definition of the special purpose served by such placement as part of the life-management plan of each individual;

C. Establishment of an individually appropriate and realistic personal/social development goal to be accomplished by each such placement;

D. Regular liaison with the facility to ensure:

1. That time spent in residence is limited to the time requirement to accomplish the established goal;

2. That service provided by the facility is consistently more suitable than the person might receive in the community.

[9] E. Pre-release counseling services to resident and family, referral with follow-through to appropriate com-

munity resources for post-release services, and follow-along responsibility for post-release life management.

F. Provision of short-term inpatient, emergency, outpatient, partial hospitalization and rehabilitation and training services when and as indicated by individual life-management plans;

G. Nursing home care for older individuals primarily in need of medically supervised nursing services;

H. Supervised sheltered personal care living arrangements (groups or singly) for those whose primary need is not medical;

I. Foster Home Care — individual and group living.

U.S. Ex. 5

Pennhurst State School and Hospital
Memorandum — Inappropriate Commitments

May 15, 1975

[-2-] The social service department, as responsible for the coordination of pre-admission and admission services, has made the courts, Base Service Units, and MH/MR Centers aware of administrative policy of our facility in regard to admissions. All of these agencies are aware of Pennhurst's physical conditions and understaffing. It has been the thrust of the social service department to insure the seeking out and use of every possible alternative service for the person needing residential care and locating of appropriate community services for those not in need of residential care.

In effect, we oppose every commitment to Pennhurst. Some are opposed more vehemently than others. In the case of children and adults who urgently need residential care, who are appropriate candidates for admission, and for whom there is no other alternative, we are less vocal in our opposition. For others, there is clear indication that Pennhurst is not an appropriate facility for their needs, and in these situations strong opposition has been raised against commitment here. Referring and committing agencies have and have not been sensitive to the inappropriateness of commitment here.

The following selected cases illustrate instances where we have vehemently opposed admission yet the children and adults were committed here:

1972 commitments:

_____ b. 4/28/72 — adm. 8/2/72 — BSU, Hall-Mercer committing court — Philadelphia Court of Common Pleas, Family Court Division. This commitment was opposed because of Pennhurst's inability to provide the care needed by a child so young and on the basis that retardation

could not be documented. Although committed to Pennhurst, _____ was transferred to St. Joseph's Children and Maternity Hospital, Scranton, shortly after her admission.

_____ b. 10/5/56 — adm. 8/18/72 — BSU, Episcopal committing court — Philadelphia Court of Common Pleas, Family Court Division. Commitment was opposed on basis of Pennhurst being inappropriate for _____'s needs. _____ was transferred to Embreeville Environmental Enrichment Program November 27, 1972.

1973 commitments:

_____ b. 8/17/58 — adm. 12/27/73 — BSU, Chester-Crozier committing court — Delaware County Juvenile Court. Commitment was opposed on the basis that Pennhurst could not appropriately provide for _____'s needs. He was seen as a culturally deprived young man and retardation was questioned. Upon admission, psychological evaluation indicated _____ was not retarded. Despite efforts to find a more adequate placement, _____ remained at Pennhurst until transfer to Youth Forestry Camp in March, 1975.

[-3-] 1974 commitments:

_____ b. 1/27/14 — adm. 5/1/74 — BSU, PATH committing court — Philadelphia County Court of Common Pleas — Master's Hearing. Commitment was opposed on the basis of _____'s needs being geriatric as he was 60 years of age. _____ was committed here with BSU and Pennhurst State School to pursue appropriate placement. No facility has yet been located for _____ and he remains at Pennhurst.

_____ b. 7/18/06 — adm. 8/19/74 — BSU, Penn Foundation committing court — Bucks County Court of Common Pleas. Commitment was made without knowledge to us. _____ arrived at

Pennhurst without any notice. Following evaluation here, nursing home placement was recommended to and secured by the Base Service Unit. Is doing well at the nursing home and was discharged from Pennhurst in March, 1975.

_____ b. 10/23/59 — adm. 9/11/74 — BSU, Philadelphia Psychiatric Center — committing court — Philadelphia County Court of Common Pleas — Family Division. Commitment was opposed on the basis of _____'s level of functioning — retardation was questionable and our resulting inability to provide appropriate programming to meet his needs. He was committed to Pennhurst for 60 days pending evaluation and referred to Woodhaven on January 29, 1975 after court intervention. Psychological evaluation here indicated _____'s functioning to be above the retarded level.

1975 commitments:

_____ b. 7/15/50 — adm. 3/26/75 — BSU, Hahnemann committing court — Philadelphia County Court. We received notice of hearing for commitment for _____ the morning of 3/12/75. Hearing was scheduled for afternoon of 3/12/75. Philadelphia Public Defenders office was told we had no information about _____, therefore we were not in a position to accept him. Suggested inpatient evaluation at BSU for evaluation. _____ was committed to Pennhurst State School on March 12, 1975. BSU representative at the court hearing was not permitted to testify. Commitment is felt to be inappropriate as _____ requires more structured program than we can provide.

_____ b.d. 7/9/64 — adm. 4/21/75 — BSU, Philadelphia Psychiatric Center. Despite our opposition, _____ was admitted on a voluntary admission by order of the Regional Commissioner of Mental Retardation. Although recognizing the family's

need for relief of the care of_____, admitting this child on a voluntary application superceded the rights of other families who have been required to gain admission to Pennhurst through the court process.

I hope this will be helpful.

U.S. Ex. 15

Cumulative Accident Summary (12/29/76 - 1/29/77)

	Date	Who	Location and Action
Major:	1/21/77		3 sutures on forehead.
	1/18/77		3 sutures on eyebrow.
	1/16/77		Fracture finger.
	1/1/77		Cut own arm deliberately, sutured.
	1/17/77		Laceration of left side of forehead — 3 sutures.
	1/8/77		Laceration of occipital area — 4 sutures.
	1/2/77		Laceration of lower lip — 6 sutures.
	1/3/77		Laceration on back of head — 5 sutures.
	1/5/77		Laceration of nostril — sutured at Phoenixville Hosp.
	1/12/77		Laceration on back of scalp — 3 sutures.
	1/19/77		Laceration of forehead — 3 sutures.
	1/13/77		Laceration on left side of head — 2 sutures.
	1/12/77		Laceration on occipital area — 3 sutures.
	1/23/77		Laceration over eyebrow — 9 sutures, laceration on nose — 4 stitches.
	1/4/77		Possible dislocation.
	1/8/77		Broken foot.
	1/3/77		Sutured finger.
	12/29/76		Loose tooth, extracted.
	1/10/77		Lacerated head, 3 sutures.
	12/31/76		Lacerated head, 3 sutures.
	1/25/77		Lacerated head, 1 suture.

Date	Who	Location and Action
1/21/77		Lacerated head, 3 sutures.
1/21/77		Head, self-inflicited, sutured.
1/26/77		Cut right eyebrow, 4 sutures.
1/12/77		Fall, 6 sutures to brow.
	25	

Minor:	Self	299	+ 41	=	340
	Others	240	+ 43	=	283
	Misc.	162	+ 48	=	210
					833

Accident Summary (Tabulation on 3/1/77)

Totals to All Units (1/29 - 2/28/77)

	Date	Who	Location and Action
Major:	2/5/77		Fall, suture eyebrow.
	2/14		Pushed, suture lip.
	2/4		Cut forehead, 4 sutures.
	2/18		Fracture toe.
	2/9		1 suture to forehead.
	2/24		Cut left brow, 5 sutures.
	2/19		Cut left brow, 3 sutures.
	2/17		Cut right brow, 4 sutures.
	2/3		Cut brow, 4 sutures.
	2/6		Cut forehead, 4 sutures.
	1/30		Fell, lost tooth.
	2/5		Bit in lip, 6 sutures.
	2/2		Fell, 4 sutures to head.
	2/8		3 sutures to scalp.
	2/14		Cut finger, 4 sutures.
	2/6		Cut eye, opthamologist.
	2/13		Fell, 3 sutures to head.
	2/15		Ran, fell and cut lips and gums. Sutured.
	2/11		Cut shoulder on bed frame, 3 sutures.
	2/24		Cut brow, 3 sutures.
	2/25		Cut brow, 2 sutures.
	?		Cut brow, sutured.
	2/5		Cut brow, 7 sutures.
	2/4		Bit ear, 10 sutures.
	2/15		Cut brow, 4 sutures.
		25	

Minor:	Self	129
	Others	230
	Misc.	205
		564

Accident Summary (Tabulation on 3/1/77)

Unit	Major	Minor - Self	Others	Miscellaneous	Minor
1	1	10	15	5	30
2	2	18	11	12	41
3	2	17	15	16	48
4	3	15	3	10	28
5	3	10	36	21	67
6	2	8	32	40	80
7	6	15	35	31	81
8	4	23	28	10	61
9	2	13	55	69	137
Hosp. — No Reports					543

Submitted by J. F. Brody, Ph.D.

keg

cc: Executive Staff
Unit Directors
H. Francis
D. Pool
J. Hipple

U.S. Ex. 48 (INDEX)*

Photographic exhibits:

Dr. Clements: (3/26/75)

Photo	Ward	
1	C-9	Bathing of residents (Non-amb. female bathing area)
2	C-9	Dorm area (Non-amb. female bedroom)
3	C-9	Resident in bed
4	K-1	Residents in wheelchairs Ward K-1 dayroom
5	K-1	Toilets
6	K-1	Bathroom radiator & pipe
7	K-1	Bathroom sinks
8	K-2	Male dayroom
9	K-2	Bedroom
10	K-2	Toilets
11	C-9	Wooden cart in female non-amb. ward
12	C-9	Non-amb. female dayroom
13	D	Basement — Motor training room
14	D-3	Child in dayroom floor
15	D-2	Bedroom
16	D-2	Bedroom
17	D-4	Bedroom
18	Q-1	Male in restraints
19	Q-2	Bedroom
20	H-1	Child in bed
21	48	Dayroom
22	52	Run in corner at end of hallway
23	52	Men asleep on floor
24	52	Boy asleep on dayroom floor
25	52	Boy's scarred head
26	47	Dayroom
27	47	Dayroom

*Photographs admitted into evidence as U.S. Ex. 48 are presented to the Court in a separate volume of the Appendix.

28	47	Female on dayroom floor
29	47	Bedroom
30	47	Bedroom
31	48	Dayroom
32	48	Corridor
33	50	Dayroom (3 females, TV, connecting door)
34	Bldg 2	Dining area in basement
35	Bldg 2	Bedroom
36	Unit 3	Basement dining area — Female eating dinner
37	Unit 3	Basement dining area — Female taking anothers food
38	C-8	Aide giving medication to resident
39	C-13	Showers
40	C-12	Sleeping area (non-amb.)
41	C-12	Sleeping area (non-amb.)
42	C-8	Towels on hallway floor
43	C-8	Female exiting shower
44	C-8	Aide drying resident

Photographic exhibits:

Dr. Roos: (4/7/75)

Photo	Ward	
45	D-1	Bed with restraints
46	K-1	Bathroom with 3 residents
47	Hospital	Male in restraints
48	Hospital	Female in restraints
49	Hospital	Blind female in restraints
50	C-4	Uncleaned toilet
51	C-14	Young lady

(3/1/77)

52	H-2	Women residents in dayroom
53	Q-1	Resident by radiator in sleeping area
54	Q-1	Same resident lying on dayroom floor
55	C-6	New Horizons resident on hallway floor

Photographic exhibits:

Dean Settle:

Photo	Ward	
56	C-6	New Horizons residents in dayroom
57		DELARC work activity center — Upland
58		DELARC — Upland
59		660 Burmont Rd. — resident in dining room
60		660 Burmont Rd. — resident with pet Afghan "Bixby"
61		Pennhurst resident
62	M-2	Resident
63		Pennhurst resident
64		Pennhurst resident
65		Resident in Pennhurst workshop
66		Resident in Pennhurst workshop
67		Resident in Pennhurst workshop
68		Pennhurst workshop

Photographic exhibits:

Linda Glenn:

Photo	Ward	
69		500 N. Franklin (Pottstown) women resident in living room
70		Interac 300 Parker Ave. Apts.
71		300 Parker Ave. Apt. living room
72		1314 Federal St. — women residents in kitchen
73		6224 Wissahickon Ave. — boys in living room
74		6224 Wissahickon Ave. — outside of home
75		EMAN 143 E. Mt. Airy — 3 women residents
76		143 E. Mt. Airy — outside of home
77		EMAN 143 E. Mt. Airy — view from porch
78		Interac Shoremont Apts. bathroom
79		Interac Shoremont Apts. — resident in bedroom
80		Interac Shoremont Apts. — resident by bedroom closet
81		EMAN 729 Vernon Rd. Kitchen
82		EMAN 729 Vernon Rd. Bathroom
83		EMAN 729 Vernon Rd. — resident in his room by T.V.

Photographic exhibits:

Dr. Girardeau:

Photo	Ward	
84		West Chester Apts. — bedroom
85		West Chester Apts. — residents
86		River Crest School — activities center
87		River Crest School — activities center
88		River Crest School — activities center
89		MARC Infant Motivation Program
90		2923 Garrett Rd. apt. living room
91		Garrett Rd. apt. bedroom
92		Lynch Home — children
93		DELARC work activity center
94		Keystone Learning Center — class in session
95		Keystone Learning Center — noon meal
96		Mod unit #2 dining area
97	Q-1	seclusion room bed
98	Q-1	seclusion room pipe
99	Q-1	basket ball court/dayroom & 2 residents
100	D-4	time out room (inside)
101	D-4	time out room (outside)
102	D-3	sleeping area
103	D-1	day room and residents in wheelchairs
104	T-2	regular entrance to ward
105	T-1	toilets
106	T-1	showers
107	T-1	sleeping area
108	T-1	day room and residents